Post-acute Prospective Payment: What You Should Know

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Post-acute prospective payment is one of the latest reimbursement changes to affect healthcare. How does it work, and how will it affect HIM professionals? The authors offer an overview of the new system.

Volumes have been written about the spiraling healthcare expenditure crisis and the need to contain costs. One particular object of concern has been Medicare, the nation's largest health insurance program. In 1997, the US government took a significant step toward reform in healthcare reimbursement with the Balanced Budget Act. This law not only cut Medicare spending growth but altered the payment structures of the program -- with ramifications for many areas of delivery, especially post-acute services.

The new reimbursement system is commonly known as the post-acute prospective payment system (PPS). It is driven by health information provided directly by clinicians -- information that will directly affect a facility's reimbursement level.[1] So much so that if facilities cannot provide very specific health information within a rigid timetable, they risk losing money. As a result, the PPS brings health information into the spotlight. HIM professionals will recognize the system's emphasis on the importance of capturing data in an accurate and timely manner.

In this article, we'll look at how the new post-acute system works and its effect on clinical operations and the management of health information.

Evolution of a System

The PPS system for skilled nursing facilities (SNFs) became effective on July 1, 1998. Other changes mandated by the Balanced Budget Act of 1997 will be phased in over time. But the story doesn't begin there. As far back as 1987, the Health Care Financing Administration (HCFA) began to address the problem of Medicare cost control. The first step followed the Omnibus Budget Reconciliation Act of 1987, when long term care facilities were advised that HCFA would develop an assessment tool to standardize the collection of patient data.

Eleven years later, this assessment is known as the Resident Assessment Instrument (RAI), which includes:

- the Minimum Data Set 2.0 (MDS) -- the minimum set of information about a patient. The MDS is the cornerstone on which all other documentation and reimbursement rests. This information has been collected in nursing homes for some years, but starting in June 1998 it has been required to be collected and transmitted electronically
- triggers -- specific responses alerting the assessor to delve further for clarification
- resident assessment protocols (RAPs) -- protocols that identify the nature of the condition that may or may not be a current problem, complications, risk factors and the need for referral(s)
- utilization guidelines -- the timetable and reasons for patient assessment

The PPS Rationale

The PPS payment methodology is based upon assessing the resource needs of individual beneficiaries. All skilled nursing facilities (SNFs) will receive the same payment for services rendered to individuals with similar needs (except for geographic, urban/rural, and market value adjustments).[2] Payment is based on a resident's categorization in Resource Utilization Groups (RUGs).

The RUGs were one of the first post-acute models of reimbursement to be implemented. Medicare is now using the third and most current version of the groups. Using resident information collected in the MDS, patients are classified into one of 44

possible RUG III categories, each with a corresponding per diem reimbursement rate. (In reality, there is a 45th group, which represents those patients for whom an error in assessment or missed deadline has created a default.)

The PPS method of reimbursement assumes that the case mix system developed by HCFA's research (the Nursing Home Case Mix and Quality Demonstration project) is the most practical and effective method to categorize patients and their needs. It also assumes that the monetary value assigned to the RUGs reflects an equitable payment based on the quantifiable data obtained from the MDS. (There is some controversy as to whether the RUGs III categories adequately reimburse for non-therapy ancillaries.)[3]

How It Works

The new system consolidates routine care, ancillary services, and capital costs into one payment. Beneficiaries of the Medicare program are eligible for Part A services at a long term care facility if all of the following criteria are documented as being met:

- the patient had a qualifying three-day stay in an acute care facility within the previous 30 days
- the patient has benefit days available to him/her (maximum 100 days)
- the long term care facility is currently a participant in the Medicare program
- the bed location assigned to the patient is classified as "certified"
- the physician of record signs orders indicating the reason for skilled services
- the patient is assessed to be capable of receiving benefit from said skilled services

As part of the billing process, all patients are coded for diagnoses and procedures. The Health Insurance Prospective Payment System (HIPPS) is an extended billing code. The code is made up of five digits: the first three are derived from the RUG III group and the last two represent a modifier code for the specific assessment. This code is then recorded on the UB-92 Medicare bill. Any patient who is coded in one of the top 26 RUG III groups is, by definition, a skilled patient.

The payment that the long term care facility eventually receives is based on the patient's current RUG III group classification (which, in turn, is derived from information collected in the MDS).

For a facility to be reimbursed for a patient's stay, it must produce an accurate assessment and promptly submit it to a state database repository. The state forwards this patient billing information to HCFA, which reimburses the facility. (A word of caution: a facility should think twice before submitting the default code "AAAOO" on the billing document. This most commonly occurs when a provider fails to submit data in the proper time frame. The use of the default code will result in the lowest reimbursement -- an oversight no provider can afford.)[4]

The MDS: Issues of Capturing and Transmitting Data

HIM professionals who are held accountable for clinical and demographic information about patients in long term care facilities must understand the difference between the RAI and the MDS. Currently, the definitive source document for RAI construction is HCFA's *Long-Term Care Facility Resident Assessment Instrument User's Manual*, issued in October 1995. This manual will be updated in the near future, but it is the best teaching reference available at this time.

The content of MDS version 2.0, used by all Medicare skilled facilities, includes the:

- *basic assessment tracking form* -- used when any MDS is completed
- full assessment form MDS version 2.0 -- used for full RAI submission and PPS assessments for reimbursement
- *quarterly assessment form* -- subset of items used for OBRA assessments
- *RAP summary form* -- section V of the full MDS that documents triggered RAPs
- *supplemental section T* -- used only for PPS reimbursement MDS

The RAI (which includes MDS 2.0) used by all Medicare skilled facilities includes the:

- *basic assessment tracking form* -- section AA
- *background information at admission form* -- sections AB, AC, and AD
- *full assessment form MDS version 2.0* -- sections A through R
- completed RAPs as indicated from the triggers discovered using the MDS
- *utilization guidelines* directing professional staff on care plan development

The RAI and the MDS may include additional sections of the comprehensive assessment, as mandated by state requirements:

- *state-specific* -- section S, reserved for each state
- *supplement* -- section T
- *medications* -- section U

The content of tracking forms used to electronically chronicle the patient's utilization of Medicare skilled facilities includes the:

- *discharge tracking form* -- a repeat of Section AA, items 1-9, but only the three discharge codes from Item 8, which is reason for assessment
- *reentry tracking form* -- a repeat of Section AA, items 1-9, but only one code from Item 8, which is reason for assessment

HCFA policy requires all facilities to maintain 15 months of patient assessment data in the active clinical record. This includes all components of the RAI and the tracking forms used to indicate when and why a patient came into or was discharged from the facility. Each facility is free to establish and implement its own written policies regarding readmission procedures, so long as the timetable of 15 months does not restart with each readmission.

The hard-copy collection of assessment data may be eliminated if the computerized record system can reproduce a printed copy for the 15-month assessment period and:

- the facility has a back-up system to prevent data from loss or damage
- the assessment data is accessible to staff and surveyors
- the system complies with HCFA's standards for safeguarding patient confidentiality

To Learn More

Several Internet sites offer information on the subject of MDS and RUGs III reimbursement. These sites should be checked frequently for updates and clarifications by HCFA.

The HCFA home page, at http://www.hcfa.gov/, is the gateway to Medicare and Medicare rules, regulations, and more.

HCFA's MDS 2.0 state information page, at http://www.hcfa.gov/medicare/hsqb/mds20/state.htm, also offers the user's manual for RAI.

Go to http://www.hcfa.gov/medicare/hsqb/mds20/whatsnew.htm for the latest information on MDS.

Playing by the Rules: Compliance Issues

Fraud Watch

In recent years, federal investigators have found fertile ground for fraud in healthcare. The Department of Justice shows no signs of decreasing its scrutiny for Medicare fraud. What's more, if Congress accepts the proposed budget for fiscal year 2000, HCFA will receive additional funding to support a 19 percent increase in survey and certification activity. Both the Medicare Integrity Program (MIP) and the Health Care Fraud and Abuse Control Program (HCFAC) may receive increased funding.

As a result, healthcare professionals must continue to make sure that they are in compliance with federal guidelines. With any submission for reimbursement, clinical and clerical compliance issues must be addressed. Clinical issues may be debated using interpretive guidelines during the survey process. Clerical compliance issues, however, cannot be argued. There is no acceptable excuse for missing a deadline for submission of the complete and accurate RAI for OBRA. Failure to submit within the prescribed time line may result in a facility receiving a citation or a monetary penalty -- and losing the highest PPS reimbursement.

Furthermore, assessments that are in error but nonetheless are submitted for reimbursement under PPS may be considered fraudulent. To remain in compliance, management should employ several strategies to ensure the integrity of patient assessment data:

- select proven vendor software for RAI collection, storage, and transmission
- cross-train all members of the interdisciplinary team on RAI techniques
- cross-train staff to ensure understanding of the need for quality data
- have resources/references available to all team members
- run global statistics as often as necessary to monitor QI indicators for the facility
- keep a master schedule (confidentially) at workstations, indicating the status of each patient assessment

Quality Time

Issues of compliance go beyond correctly submitting the right information, however. A patient assessment should provide enough information about a patient's clinical problems so that a clinician can plan care that yields positive results. HCFA requires that a plan of care must be developed within seven days of completion of the comprehensive assessment and must include "measurable objectives and timetables to meet a resident's medical, nursing, and mental/psychosocial needs that are identified in the comprehensive assessment."[5] The services rendered on behalf of the patient must also "attain or maintain the resident's highest practicable physical, mental and psychosocial well-being."

Through the electronic submission of the MDS, HCFA will now have the facility documentation necessary to remotely monitor the progress of care rendered to patients in skilled facilities. The electronic submission of MDS data for PPS reimbursement will create databases that can produce statistical data about an individual facility which can then be compared to state and national norms. Surveyors will be able to review facility-specific statistics without even leaving their offices.[6]

Surveyors will be able to view indicators such as the prevalence of wounds, indwelling catheters, psychotropic prescriptions, and other conditions. These can be reviewed and compared not only to a facility's previous measures, but to regional and national values for the same time period (using the Online Survey Certification and Reporting System [OSCAR] Reports 3 and 4). A facility's management team will be able to access and review this information, too, if they are performing good quality assurance reviews.[7]

The More Things Change -- The Operational Outlook

The PPS requires that patient assessments be completed in concert with the required RAI assessments to maintain compliance with Medicare Conditions of Participation. It should be noted that these assessments have a shorter completion deadline than the OBRA RAI assessments. HCFA, realizing that these tighter timelines could create an undue hardship for some facilities, has offered an extension in the form of "grace periods" for PPS submission. (It is worth noting that this grace period does not apply to OBRA submissions, and that the first day of admission is counted differently between the two assessment activities.)

Professionals participating in the patient assessment process must understand and work within the two "clocks" that determine when an assessment is due. (Table 1 demonstrates the documentation requirements and associated time lines.)

Table 1 -- MDS Submission for RAI vs. PPS

Reason for Assessment	Document required	Deadline	Grace	Covers
OBRA Admission	-Basic tracking form -Face sheet at admission -Full MDS, sections A - R	Within 14 days Admission day counted as day 0	None	First quarter of patient stay, unless a significant

	-RAP summary form V -State mandated sections * Section S * Section T case mix * Section U case mix -RAPS			change occurs; starts OBRA 12-month cycle
OBRA Annual	Same as admission, except face sheet is omitted	By the end of 365th day	None	Every 12 month obligation for full RAI assessment
OBRA Significant change in status	Same as admission, except face sheet is omitted	Within 14 days of significant change occurrence	None	First quarter of a new 12-month cycle
OBRA Significant correction of prior assessment	Same as admission, except face sheet is omitted	Within 14 days of error discovery	None	First quarter of a new 12-month cycle
OBRA Quarterly	-Basic tracking form -Subset of full MDS, including HCFA items plus any state-mandated items for review	Within 3 months of the last assessment, not to exceed 3 in a year	None	Every 3 months sub-set assessment
OBRA Discharged -- return not anticipated	-Discharge tracking form -Limited subset of MDS items	Day of discharge	N/A	Counts days in facility prior to discharge
OBRA Discharged -- return anticipated	-Discharge tracking form -Limited subset of MDS items	Day of discharge	N/A	Counts days in facility prior to discharge
OBRA Discharged prior to completing initial assessment	-Discharge tracking form -Limited subset of MDS items	Day of discharge	N/A	Counts days in facility prior to discharge
OBRA Reentry	-Reentry tracking form -Limited subset of MDS items	Day of admission	N/A	Counts days in facility prior to discharge
OBRA Significant correction of prior quarterly assessment	Same as quarterly	Annual schedule is not reset	None	Every 3 months subset assessment
PPS 5 day	-Basic tracking form -MDS -Section T	By the 5th day of admission; admission day is counted as day 1	3 days	Reimbursement for days 1-14
PPS 30 day	-Basic tracking form -MDS -Section T	By the 30th day	5 days	Reimbursement for days 31-60
PPS 60 day	-Basic tracking form -MDS -Section T	By the 60th day	5 days	Reimbursement for days 61-90
PPS 90 day	-Basic tracking form -MDS -Section T	By the 90th day	5 days	Reimbursement for days 91-100
PPS Readmission -- return	-Basic tracking form -MDS -Section T	By the 5th day	5 days	Reimbursement cycle resets with less than 100 benefit days
Other state required	-Basic tracking form -MDS -Section T	Per state mandated OBRA timelines		Nonbeneficiary of Medicare $$
PPS 14 day	-Basic tracking form -MDS -Section T	By the 14th day		Reimbursement for days 15-30

Other Medicare required	-Basic tracking form -MDS -Section T	By the 14th day	Reimbursement cycle continues with current RUG III

For example, should an interdisciplinary team choose to complete an admission assessment RAI by the fifth day of admission and submit that for PPS reimbursement, the obligation of preparing RAPs has already been fulfilled and is not required for the 14-day PPS assessment. That is to say, only one RAI process need be completed by admission day 14 (counting the first admission day as day zero).

However, if the RAI is not completed for the PPS day five MDS submission, it must be done by day 14. The facility must decide what process is most cost effective for its operation. In facilities where the average length of stay is less than 14 days, completing an RAI may be clinically sound but costly in terms of labor.

PPS looks at services actually completed on day one of admission, so evaluations and/or treatments ordered by the physician for rehabilitation services (physical therapy, occupational therapy, and speech therapy) must be initiated as soon as possible. Hours of operation for some departments may need to be expanded to account for late-in-the-day admissions and weekend service.

New Horizons for HIM

Because it is directly tied to facility reimbursement, the post-acute PPS system endows the processes of health information management with new value. To execute an accurate MDS and complete it within a prescribed timetable requires documentation and data management skills that HIM professionals are already well acquainted with. HIM professionals in post-acute settings should avail themselves of the opportunities to use their skills and showcase their talents on the new horizons of PPS.

Systems across the Continuum

The Balanced Budget Act of 1997 has set change in motion in a number of care settings, and the effects will be felt by health professionals for some time. Here are some initiatives in areas other than long term care:

Ambulatory Care: APCs

The Balanced Budget Act mandated a prospective payment system for hospital outpatient services reimbursed by Medicare. In September 1998, HCFA published a proposed rule for the outpatient PPS, which would replace the current system of payment with one using ambulatory payment classification groups (APCs). Under the proposed system, 346 ambulatory payment classification groups (APCs) will be used to reimburse hospitals for outpatient services to Medicare beneficiaries. Under APCs, hospital outpatient services are grouped together according to their similarity in terms of resource costs and clinical indications. The payment amount for each service will be determined by the APC to which it is assigned. Implementation of this system, originally planned for 1999, has been delayed so that HCFA can complete Y2K-related work. Implementation is scheduled for hospitals and community mental health centers as soon as possible after Jan 1, 2000. A notice of implementation date will be published in the *Federal Register* in advance.

Home Health

The Balanced Budget Act requires a prospective payment system for home health agencies. As a first step, it also authorized the Department of Health and Human Services to require agencies to submit information necessary to develop a reliable case-mix system. In January 1999, HCFA published a final rule requiring agencies to electronically report data from the Outcome and Assessment Information Set (OASIS). In April 1999, however, HCFA announced that the effective date of data transmission would be delayed. Data transmission will be required 30 days after a notice establishing a system of records is published in the *Federal Register*. The data must be collected and transmitted to a state agency or HCFA contractor on a monthly basis. OASIS will provide data that will allow for the identification of appropriate clinical outcomes and reimbursement rates and pave the way for a PPS, originally scheduled to be implemented in 1999. Due to Y2K-related work, however, that deadline has been pushed back to Oct. 1, 2000.

Rehabilitation Hospitals

HCFA is in the process of developing a PPS for rehabilitation hospitals as required under the Balanced Budget Act. The agency is working with researchers to develop a case mix and classification system for rehabilitation facilities. The new system is scheduled to be implemented over a two-year period beginning in 2000.

Models of the MDS

Now that HCFA has successfully implemented the reimbursement plan within the post-acute setting, it may take the MDS process into acute rehabilitation (where a demonstration project is under way) and into home care as a mechanism for classifying several levels of post-acute care. Acute rehabilitation functional related groups (FRGs) could be layered on top of the skilled RUG III categories and the home health PPS could be layered beneath the skilled RUG III categories, thereby developing a continuum of classifications. This would truly be "post-acute nirvana" for HCFA -- one classification system for all post-acute services.

Notes

1. "PPS, MDS, and RUGs III coming for SNFs." *Health Care News*, spring 1998. Published by Berry, Dunn, McNeil, and Parker. Available at http://www.bdmp.com/igroups/hcare/newslet/spring98.html.

2. "Medicare Prospective Payment for Nursing Facilities (PPS)." *Long-Term Care Advisory*, March 1998. Published by Berry, Dunn, McNeil and Parker. Available at http://www.bdmp.com/igroups/hcare/newslet/marltcadv.html.

3. "SNF Prospective Payment System." *National Report on Subacute Care*, Jan. 13, 1999.Available at http://www.hcfa.gov/medicare/snfpps.htm

4. "MDS 2.0 Technical Information Site." Available at http://www.hcfa.gov/medicare/hsqb/mds20/default.htm.

5. HCFA's definition of the comprehensive care plan requirement is found in the *State Operations Manual*, Transmittal No. 274, issued June 1995, commonly referred to as Federal-tag 280 {¤483.20(d)(1)}.

6. HCFA. "Draft release of proposed revisions for the State Operations Manual." Feb. 8, 1999.

7. Ibid.

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