Medicare Prospective Payment — The Ethical Implications of Converging Clinical and Financial Decisions in Long-Term Care

by Don F. Reynolds

The principles of bioethics indicate that Prospective Payment has a moral dimension. Because Prospective Payment unifies clinical and financial decisions, it poses problems for long-term care facilities, especially those motivated by a humanitarian mission rather than financial considerations. This article outlines how Prospective Payment conflicts with the ethical principles of respect for persons, autonomy, justice, promise keeping, and fidelity.

In 1998, the Health Care Financing Administration (HCFA) began implementing Prospective Payment, a capitated Medicare reimbursement program for long-term care. Prospective Payment was designed to reduce the overall cost of long-term care and the federal government's long-term care reimbursement obligations, and prevent long-term care providers from obtaining financial gains that are disproportionate to the amount or the type of care provided.

Prior to implementing Medicare Prospective Payment, HCFA paid five states to operate pilot prospective payment programs. In those pilot programs, the principles of prospective payment were used to fund Medicaid reimbursements. Kansas was one of the five states that HCFA tapped to operate a pilot project. In the spring of 1998, the manager of the Kansas pilot project made a presentation to the Kansas City Regional Long-Term Care Consortium. In that presentation, she described Prospective Payment as a way to "make every clinical decision a financial decision and give every financial decision a clinical implication."

By linking clinical and financial decisions, Prospective Payment encourages facilities to become shrewd deciders of which individual residents they will admit and nimble managers of the care provided to aggregate resident populations.

How Prospective Payment Works

The foundation of Prospective Payment is a nursing assessment instrument, the Minimum Data Set (MDS). MDS assessments are completed and periodically updated for every resident who enters a Medicare-eligible long-term care facility. Based on their MDS scores, residents are assigned to clinical classifications and to billing categories. There are five clinical classifications — rehabilitation therapy, special/extensive care, clinically complex care, behavior/cognition problems, and reduced physical function. There are forty-four billing categories, each with a daily reimbursement rate assigned by HCFA.

Prospective Payment poses two special financial risks for all long-term care facilities that accept Medicare reimbursement. As the theory was put into practice, these financial risks also placed residents at risk.

Administered Daily Reimbursement Rates

One assumption of Prospective Payment is that care can be more efficiently provided — that is, in every billing category, reimbursement rates can be reduced without reducing the level of resident care.

Administered reimbursement poses a different risk to persons who need long-term care. HCFA may have correctly perceived that it was being gouged with billings for unneeded therapies. But in its drive to foreclose that risk, HCFA has created an environment in which needed therapies are no longer available. HCFA wanted facilities to become nimble managers of the care they provide to aggregate resident populations. But an untoward aspect of this nimbleness is that entire categories of therapy that were overabundant eighteen months ago are now unavailable.

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Capitation

Another assumption of Prospective Payment is that it pays for all of a resident's Medicare reimbursable care during the period covered by the payment. When a long-term care facility accepts a prospective payment with respect to a resident, it assumes the risk that other Medicare costs will be incurred on behalf of the resident. If those costs are reimbursable to a third party, the long-term care facility is responsible for the reimbursement.

Imagine a resident who enters a long-term care facility following the placement of a percutaneous endoscopic gastrostomy (PEG) feeding tube. Imagine that the resident's physician becomes concerned that the feeding tube is not properly placed and sends the resident back to the hospital for an examination. Under Prospective Payment, the long-term care facility, in this example, would receive payment based on the resident's billing category and incur both the anticipated costs associated with that billing category and the unanticipated costs of the examination (e.g., transportation and radiology).

Capitation also poses a different risk to persons who need long-term care. To avoid the risk of incurring unreimbursable charges by third parties, facilities are tilted in the direction of fewer outsourced services, but residents suffer when facilities retain responsibility to provide services without making the necessary investment to assure that they have sufficient internal capacity to provide those services.

The setting for this article is that Prospective Payment does not explicitly value caring for people who have low incomes or caring for people who have clinically complex health care needs. The problem that animates the article is that people who have low incomes and people who have clinically complex health care needs are at risk because Prospective Payment discourages long-term care facilities from admitting them as residents.

And the question is this: How does ethics inform a response to this problem?

The Problem Posed by Prospective Payment

Prospective Payment is based on the assumption that long-term care facilities are motivated primarily by financial considerations. It does not explicitly value caring for low income individuals or individuals who have complex health care needs. Some long-term care facilities are mission driven to care for the poor. Others are mission driven to care for the sickest among us. If these facilities remain true to their missions, they accept a financial risk for which there is no financial opportunity. Can long-term care facilities that are mission driven to care for the poor or the very sick survive a reimbursement system that rewards shrewd admission decisions and the nimble management of aggregate resident populations based on clinical and financial considerations?

Assumptions

My analysis of Medicare Prospective Payment is built on the following assumptions:

- Reducing the federal government's responsibility to pay for long-term care is necessary.
- It is good for long-term care to be available to low income citizens.
- It is good to support mission-driven facilities.
- Long-term care for low income and medically complex citizens is insufficiently reimbursed and requires subsidy. Therefore, mission-driven facilities, in particular, must be subsidized.
- Prospective Payment further increases the mission-driven facilities' need for subsidy because it reduces their reimbursement. Some mission driven facilities in our community are insufficiently subsidized to accomplish their mission in the Prospective Payment environment.
- Even mission-driven facilities that work hard to overcome the financial disincentives of Prospective Payment will decline to admit some low income citizens who require medically complex care that they would have admitted previous to Prospective Payment. Nonmission-driven facilities do respond to the disincentives of Prospective Payment by declining to admit low income citizens.
- In our community, mission-driven facilities do not have enough beds to accommodate every low income or medically complex citizen who needs long-term care. Our model for ensuring needed long-term care for low income citizens depends on the willingness of nonmission-driven facilities to provide some of this care. Therefore, a complete response to the problem posed by prospective payment must address the financial disincentives of Prospective Payment that discourage nonmission-driven facilities from caring for low income citizens.

Principles of Bioethics

The principles of bioethics provide a structured approach for responding to this problem.

In framing our response, we need to consult two sets of bioethics principles. The first set (respect for persons, autonomy, and justice) will help us to determine whether the impact of Prospective Payment has a moral dimension. The second set of principles (promise keeping and fidelity) will help us determine whether we have a moral obligation to respond to the problem, and if so, what is the nature of this obligation.

The principles of bioethics frame issues and relationships to issues in terms of their moral dimension. The essential feature that distinguishes bioethics principles from legal, clinical, or financial considerations is that the principles are always of great importance and immune from deliberate change (Hart 1961).

The following principles of bioethics inform an understanding of whether the problems that Prospective Payment causes for low income and medically complex citizens have a moral dimension.

Respect for Persons

This founding principle of bioethics claims that it is good to recognize the personal dignity of every person and to provide special protections to the dignity of vulnerable persons.

The principle of respect for persons obligates people who are interested in long-term care issues to make the lesser situated citizens who may be harmed by Prospective Payment one of their special concerns.

Autonomy

Autonomy is the claim that persons ought to be allowed to choose and follow their own plan of life and action.

Because the disincentives of Prospective Payment cause long-term care facilities to decline admission to some low income citizens and citizens with complex health care needs, Prospective

Payment may be understood as preventing those persons from leading self-ordered lives. However, because the principle of autonomy is not absolute, it would be acceptable to limit the access of low income persons or persons with complex medical needs to nursing home care if the limitation was an unavoidable consequence of taking the only plausible action to realize a greater value.

We recognize the necessity to reduce the federal government's responsibility to pay for long-term care. However, unless Prospective Payment is the only plausible way to accomplish that reduction, it offends the autonomy of low income citizens and citizens with medically complex health care needs who need long-term care.

Justice

Justice is the principle that we ought to treat like cases alike and different cases differently. Distributive justice is the claim that both the benefits and burdens available in a society should be allocated equitably. The problem of Prospective Payment and its implications for vulnerable people and the organizations that serve them are fundamentally matters of justice.

Unless Prospective Payment is the only plausible way to accomplish a necessary reduction in the federal government's responsibility to pay for long-term care, a choice among plausible alternatives has been made that is unfair to some citizens. Prospective Payment places a disproportionate burden on citizens who suffer from medically complex needs, on low income citizens, and on the organizations that serve them.

These principles of respect for persons, autonomy, and justice are sufficient to conclude that the problem of Prospective Payment has a moral dimension.

The following principles of bioethics can inform our understanding of whether our relationship to mission-driven facilities and the low income citizens they serve has a moral dimension.

Promise keeping

Promise keeping is a principle of assured outcome. When we assure another person that something will or won't happen and our assurance leads that person to understand that we have made a commitment, then our assurance is a promise that must be honored. We can be excused from our promises or commitments, but only if an unforeseeable event makes it impracticable to keep the promise. Arguably, the onset of Prospective Payment was one of those unforeseeable events that can excuse a promise-keeping obligation.

Though we as a nation have not made promises to citizens with complex health care needs or low income concerning their access to long-term care, other promises concerning that subject have been made.

Mission-driven long-term care facilities have promised low income persons that they will provide care. Both HCFA and most states have promised to support mission-driven facilities. Both Kansas and Missouri have made such promises. Churches, foundations, and other charitable givers may have promised to subsidize facilities because of their mission. Not only has Prospective Payment increased the prospect that such promises will not be kept, it may have excused some of these promises by making them impracticable.

Fidelity

Fidelity is a principle of assured effort. Since Midwest Bioethics Center is mission driven to support ethical decision making in long-term care, it is obliged by the principle of fidelity to respond when its mission is threatened.

Prospective Payment excuses, as no longer practicable, some of the promises that have been made to citizens who need long-term care, and increases the likelihood that other promises to these same people will be broken. Prospective Payment has broken the model for linking promise keeping (assured outcomes) and fidelity (assured efforts). Until a new model emerges, the clinical and business promises that are made in long-term care settings will not be reliable. The people who need nursing home care are not well positioned to mitigate the harms they are exposed to by these broken promises. The burden of the bond of fidelity increases if the people to whom it is owed are

exposed to the harms entailed by systemically broken promises.

Because we are bound by the principle of fidelity to low income citizens and to citizens with complex medical needs, we have a moral obligation to respond to the problems inherent in the Prospective Payment system. We ought to help mitigate the harm that this system causes to these vulnerable people.

The Impact of Adjusting the Medicare Prospective Payment System

No sooner had the implementation of Prospective Payment of Medicare reimbursement of long-term care started than pressure to adjust the system began to build. The case for adjusting Prospective Payment was argued on two grounds.

The need for Prospective Payment was less than imagined. Prospective Payment was established in response to two widely held beliefs. First, Medicare is not actuarially sound and is, therefore, in financial jeopardy. Second, annual federal budget deficits exacerbate Medicare's financial peril. These beliefs supported the assumption that reducing the federal government's responsibility to pay for long-term care was necessary to save Medicare. However, less than a year after it initiated Prospective Payment, the federal government recorded a budget surplus and announced its projections for continued, growing surpluses. Further, in its first year, Prospective Payment reduced the federal government's cost of paying for long-term care by twice as much as had been projected.

The negative financial impact of Prospective Payment on the long-term care industry was greater than anticipated. Prior to Prospective Payment, Medicare reimbursements were understood to be generally profitable contributions to long-term care revenues. Prospective Payment not only made Medicare a less rich revenue source, it also revealed how unbalanced long-term care revenues had become. Marginally profitable facilities, became unprofitable. In this unbalanced setting, for some facilities, Prospective Payment was more drastic than simple belt-tightening; it threatened survival.

The Future of Prospective Payment

In November 1999, Congress adjusted Prospective Payment so that over the next three years skilled nursing providers will receive an additional $2.5 billion in Medicare funding. The impact of the legislation can be measured against two standards.

Will this adjustment of the Prospective Payment system improve the long-term care industry's profitability? Probably. In its November 29, 1999 electronic briefing of its members, the long-term care industry's largest trade organization described the adjustment to Prospective Payment and announced a strategy for gaining another round of adjustments.

Does marginally improving the long-term care industry's profitability mean that needed long-term care will be more available to low income persons and to persons with complex medical needs? Not really. Facilities, including those that are mission driven to care for these people will benefit from the adjustments. Because the adjustments increase the reimbursement level for some complex medical care, some citizens who need a now favored care will benefit from the adjustment. Some citizens who need a still disfavored care may now be even less likely to receive it. The adjustment did nothing to abate the disincentive to accepting residents who will need continued, Medicaid-reimbursed care after their long-term Medicare benefit has been exhausted.

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As a theory of long-term care reimbursement, Medicare Prospective Payment poses a direct and an indirect question. The direct question is this: "Assuming that Prospective Payment causes long-term care facilities to be constantly mindful of the financial consequences of their actions, how will facilities meet their residents' needs by focusing on their own bottom-line?" The recent upward adjustment of Prospective Payment reimbursement rates buys some time in which facilities can answer this question, but the adjustment is not part of the answer.

The indirect question is this: "Assuming it is no longer subsidized by rich Medicare reimbursements, what incentives will make Medicaid a generally attractive source of long-term care reimbursements?" Answering this question is certain to be problematic, and the recent adjustment of Prospective Payment reimbursement rates do not address the problem.

Conclusion

Prospective Payment offends the autonomy and dignity of low income and medically complex citizens and offends justice within our community. Tweaking the details of prospective payment, even upward adjustments of Prospective Payment amounts, does not eliminate the affront.

If we are committed to establishing a long-term care community that is informed by ethics, the principle of fidelity calls us to act in good faith with respect to every person who needs long-term care. We may be discouraged from responding to the harms caused by Prospective Payment simply because the problem is so large. Attempting to redress such a large problem puts a great deal of stress on our capacity. However, if the problem truly has a moral dimension, failing to address it will have unfavorable implications for us as persons. If we have a moral responsibility to the citizens who have been harmed by Prospective Payment then we ought to seriously address the problem.

The principle of justice calls us to stand solidly beside our community's most vulnerable persons. Prospective Payment is another test of our will to respond when we see these vulnerable citizens being harmed.

References

Hart, H.L.A. 1961. *The Concept of Law*. Oxford: Oxford University Press.