Prospective Payment: Lessons from the U.S. Medicare Program

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Introduction and Objectives

- With the introduction of DRGs for inpatient hospital services in the early 1980s, the U.S. Medicare program began to move away from reimbursing medical care providers on a cost basis and toward paying prospectively for nearly all services.
- The movement is largely complete; Medicare pays prospectively now for services delivered in almost every setting. Common to all systgems is a predetermined payment made for a defined unit of care. Medicare's goal is to preserve access to care while giving providers an incentive to deliver care more efficiently.
- The American experience does not reflect a grand design, but a two-decade long incremental process during which successive introduction of new payment methods spawned both intended and unintended consequences. This experience provides a unique opportunity to learn what prospective payment can and cannot achieve and to the circumstances which most favor success.

Overview

- **The U.S. Medicare program.**
- **Prospective payment (AKA activity-based pricing).**
- **Medicare's experience with prospective payment.**
- **Q&A**

Why Look at Medicare?

- Medicare is the largest health care purchaser in the United States. The program pays for about 60% of the health care needs of 46 million people (2010) who are 65 or older, have end-stage renal disease, or are disabled.
- For this population, Medicare functions as a single-payer system. For about 85% of the people it covers, the program pays providers directly for services; for the others, it puts health plans (like Kaiser Permanente) at financial risk for care.
- Medicare faces challenges similar to other countries' systems:
  - As an entitlement program, Medicare cannot turn eligible people away.
  - As a political program, Medicare must be funded well enough to keep access to care and technology comparable to private insurance.
  - As a largely tax- financed program, Medicare strives to meet these goals without breaking the bank.

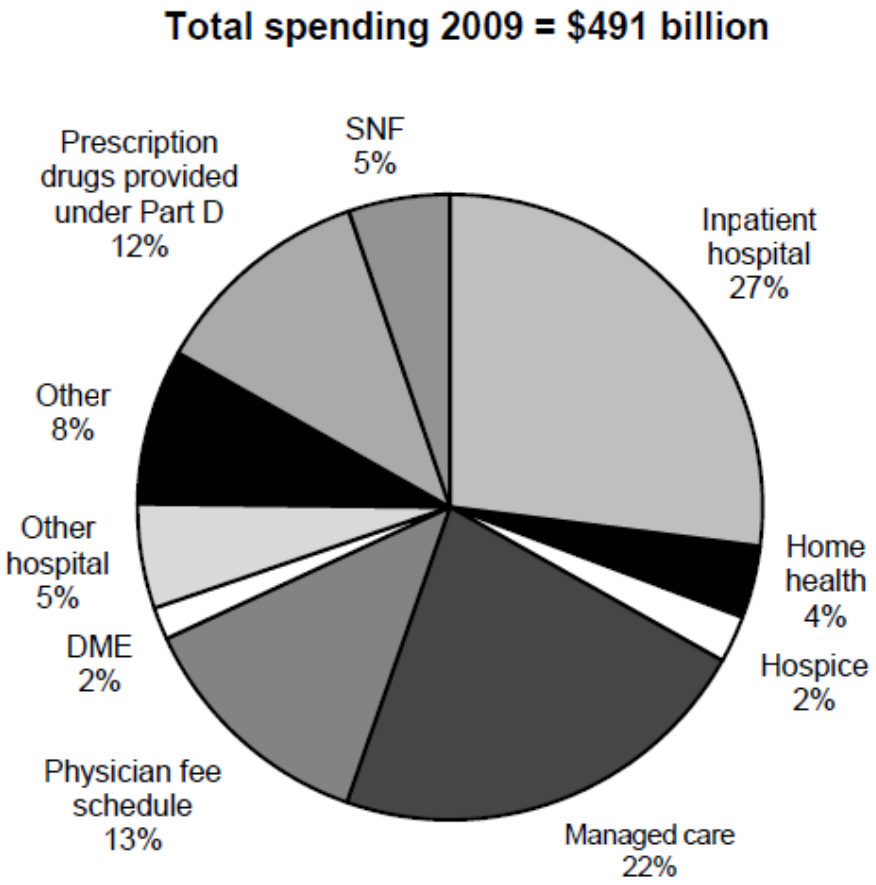
Medicare at a Glance: Benefits

- Medically necessary services & supplies for the treatment of acute illness
- **Part A** (Medicare direct payment for facility services)
  - inpatient hospital care ($**1132** deductible, coinsurance after 60 days)
  - SNF care after 3-day hospital stay (first 20 days free, $**141**/day for next 80)
  - home health and hospice care (no cost to patient)
- **Part B** (Medicare direct payment for ambulatory care)
  - physician services, DME (20% coinsurance after $**162** deductible is met)
  - outpatient, ASCs (20%-50% coinsurance after deductible), lab (no cost to patient)
- **Part C** (Medicare puts private plans at full risk)
  - pay for all Parts A/B services with actuarially equivalent cost sharing
- **Part D** (Medicare puts private plans at full risk)
  - outpatient Rx; 75/25 cost-sharing, coverage gap, catastrophic protection

Medicare at a Glance: Eligibility and Financing

- **Eligibility**
  - Age 65 and older: People who have worked (or spouse has worked) 10 years enroll in Part A at no charge, may choose to enroll in Part B by paying a premium
  - Under age 65: certain people with disabilities, all with end-stage renal disease
- **Financing**
  - **Part A**: 1.65% payroll tax levied on employers and workers
  - **Part B**: beneficiary premiums cover 25% of spending ($115/month in 2011)
    - general revenues cover the remainder
  - **Part C**: private health plans paid from Part A/B funding
    - plans may collect additional premium directly from enrollees
  - **Part D**: beneficiary premiums cover about 25% of spending
    - general revenues cover the remainder

Composition of Medicare Spending, 2009



Source: Medicare Payment Advisory Commission

Goals of a Payment System

- Medicare is but one payer in the U.S. health care marketplace and provides no care directly. Medicare thus makes reimbursement decisions around individual services and patients, not budget decisions for a population.
- At a minimum, payments (plus patient cost sharing) must cover providers' variable costs. To avoid access barriers, payments must also account for:
  - variation in illness severity among beneficiaries, and
  - geographic variation in the costs of furnishing care.
- Cost reimbursement meets providers' revenue needs and accommodates both sources of variation automatically; creates no incentive for efficiency.
- Prospective payment can match resources to patient needs and introduce an element of efficiency. Critical: put providers at risk for the costs of care.

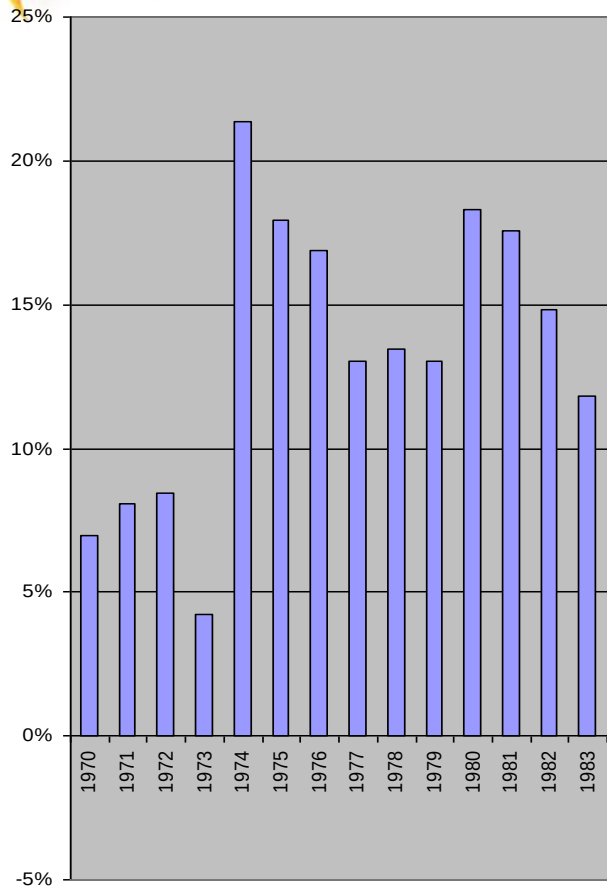
Elements of a Payment System

- **Unit of payment**--a service, day, or episode of care
  - what is included in the service "bundle" and what is not?
  - the larger the unit, the greater the potential efficiency
- **Classification scheme** for services and/or patients
  - costs of services/patients vary and we price everything, so need to group
- **Relative values** to account for variation in resource needs
  - need to attach higher payments to services in higher cost groups
  - want to adjust for variation in costs that are not under the control of providers
- **Other adjustments**
  - reinsurance for cost outliers can protects providers and patients
  - some providers may differ from others in systematic ways (say, low-volume rural)

Setting Payment Rates

- Given a payment system, two decisions must be made:
  - an initial payment rate must be set, and
  - payments must be updated over time.
- Easiest way to set initial payment rates: divide existing spending pool by number of payment units, adjust for differences in case mix, input prices.
  - This is roughly what Medicare has done over the years, but we've added $$ to the pool ("just in case") sometimes and shrunk the pool to get savings in others.
- How payment rates are updated over time is critical:
  - Unless growth in unit prices is restrained, there is minimal budgetary advantage over cost-based reimbursement. (Incentives at the margin don't help if average is too high.)
  - But if growth is too restrained, access to care is impaired.
  - Need to account for new technology, increases in case mix, and other factors.

Why Prospective Payment? Medicare $/Person 1970-83



Source: Centers for Medicare and Medicaid Services

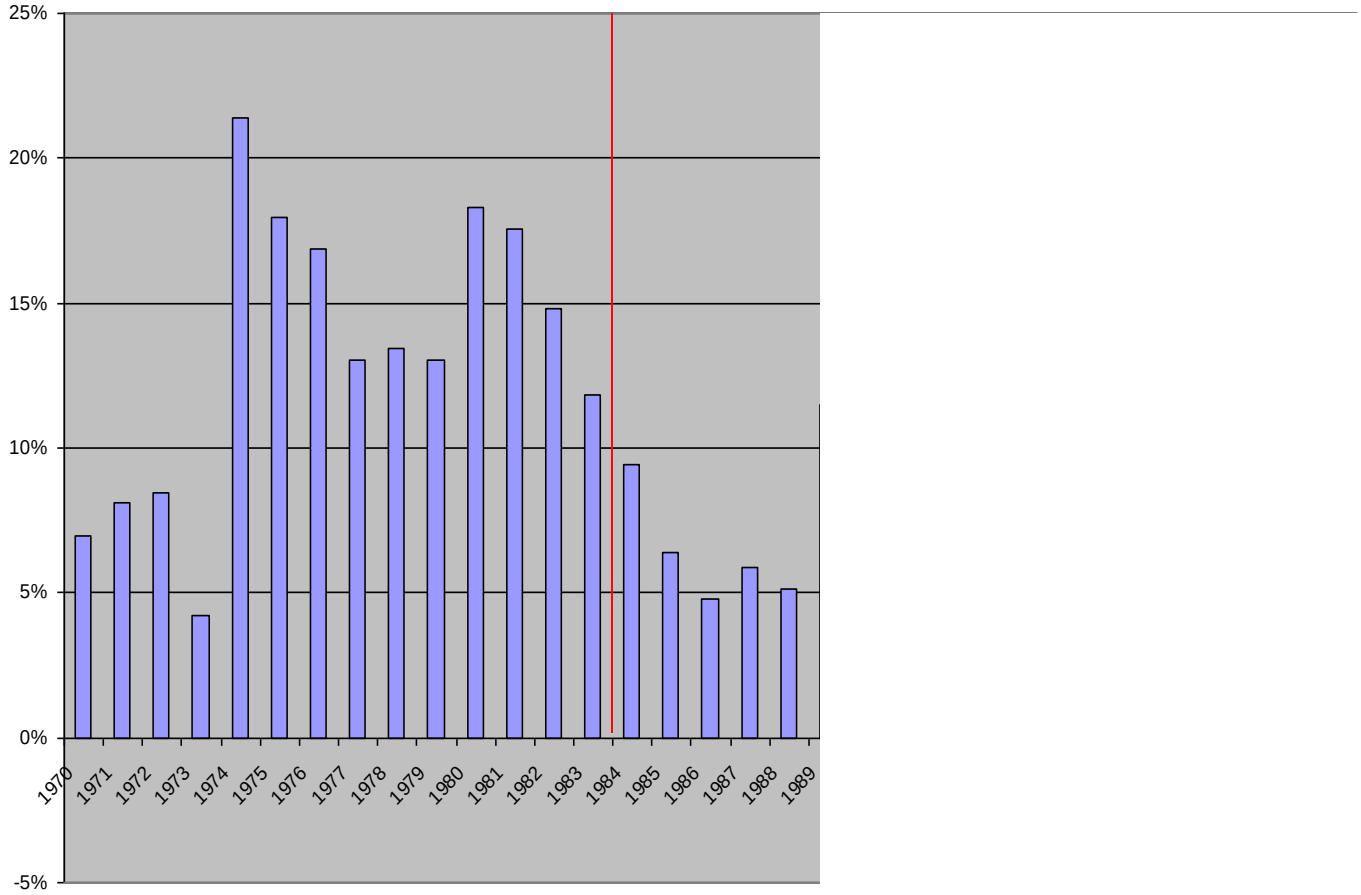
How DRGs were Implemented

- **Unit of payment**: a discharge
  - services included were 72-hour pre-op; limited recovery time
  - only hospital costs included—no physician, post-acute services
- **Classification scheme**: Diagnosis Related Groups (DRGs)
  - patients classified by discharge Dx, distinctions for complications, service use
- **Relative values**
  - hospitals' charges; converted to $ based on a "standardized amount"
  - "labor-related" portion of the base adjusted using a wage index
- **Other adjustments**
  - base payments adjusted for "teaching intensity"
  - separate adjustment for hospitals with a large share of low-income patients

What Happened?

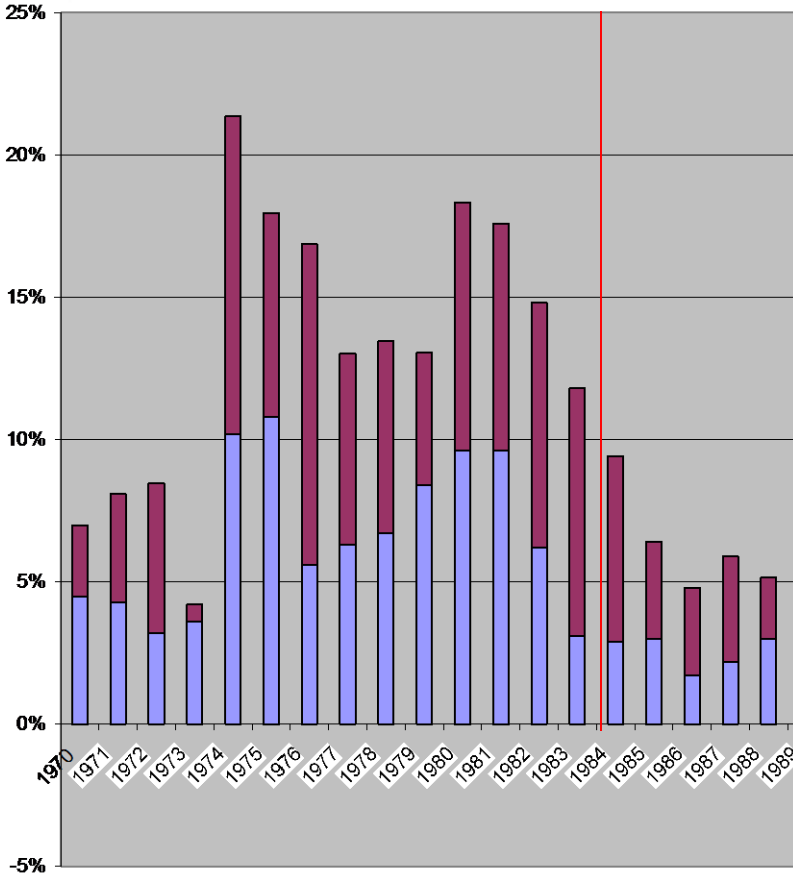
- In the short run, implementing DRGs appears to have had exactly the effect on Medicare spending that policymakers intended.
  - Spending growth per enrollee dropped from 15% annually in the six years prior to implementation to 7% annually in the six years after.
  - Some of this reflects lower overall inflation in the latter period, but roughly half of the decline reflects lower real costs.
- But the notion that hospitals would become more efficient in response to prospective payment was not immediately evident, as operating costs per case continued to rise by about 9% annually.
  - With policymakers keeping a tight lid on payment updates, the result was a dramatic decline in margins.
  - Hospitals' inpatient Medicare margins fell from about 13% in 1984 to -1.5% in 1990.

Growth in Medicare $/Person After Adoption of DRGs



Source: Centers for Medicare and Medicaid Services

“Excess” Growth in Medicare $/Person After DRGs



Blue = Inflation

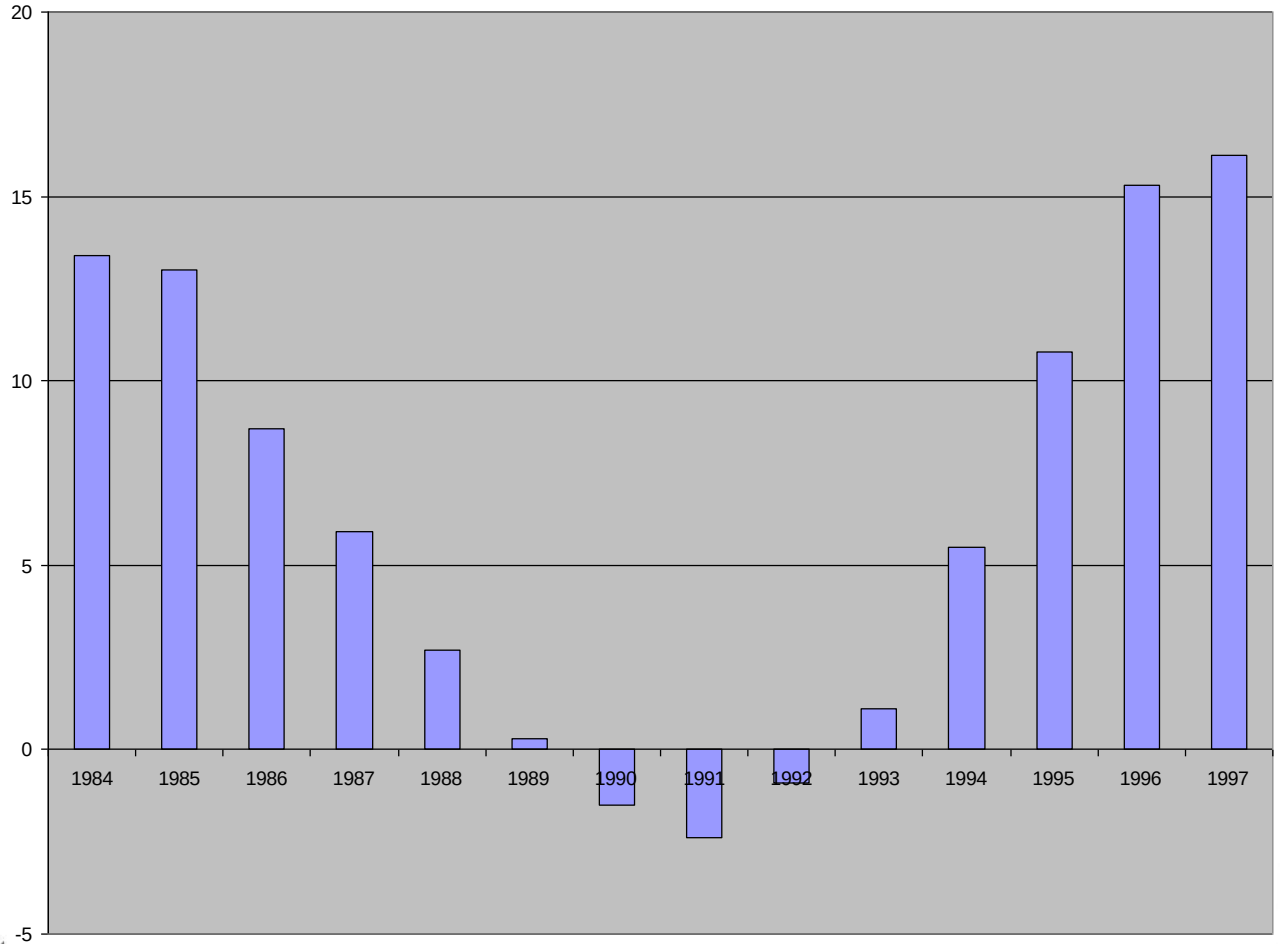
Red = Excess

Source: Centers for Medicare and Medicaid Services

Hospitals' Responses

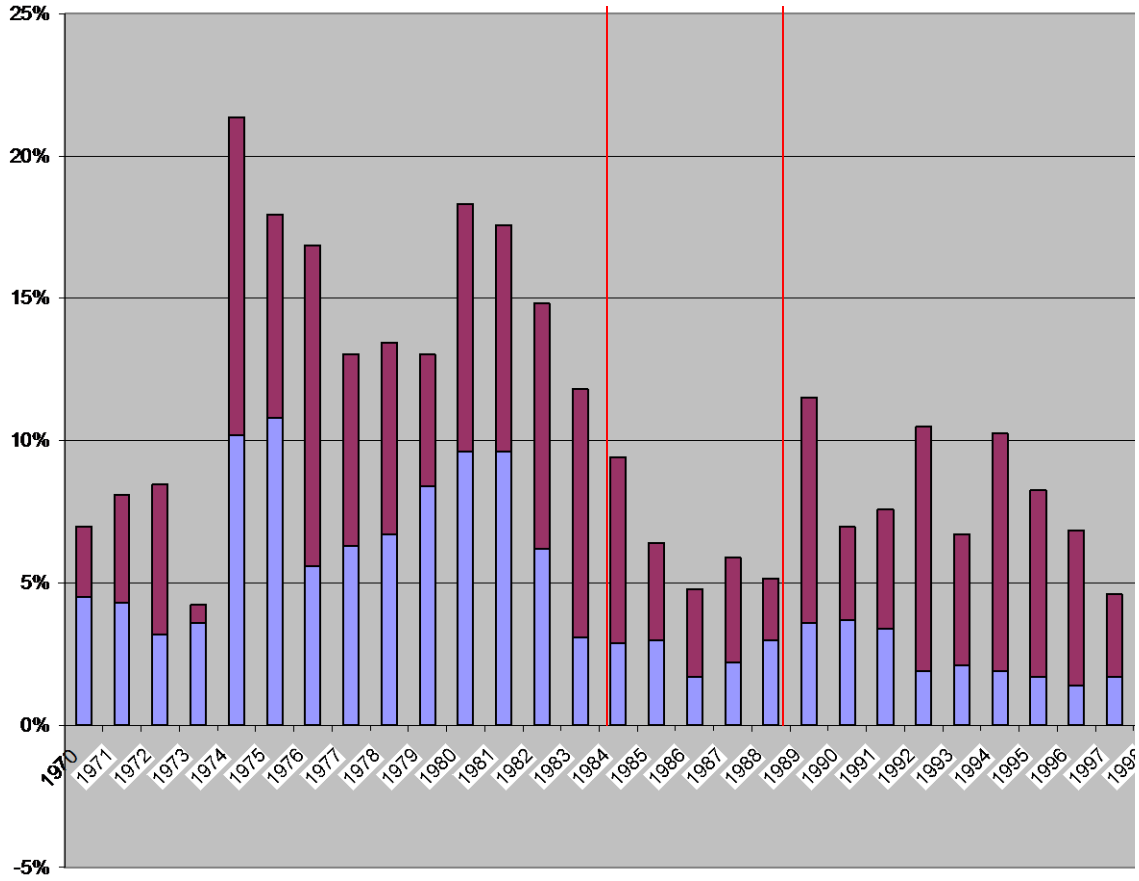
- **Improved coding**
  - Case-mix index increased about 2.5% annually during 1980s; 1/3 to 1/2 upcoding?
- **Reduced length of stay**
  - from 7.0 to 6.5 days in 1984-1990, down to 5.5 days by 1996 (now 4.9)
- **Transferred patients** to post-acute care settings
  - User of lower-intensity setting should be good, but Medicare did not adjust its payments downward to match the product change.
  - It paid again for the same care because PAC was still cost-based.
- **Reallocated overhead** to outpatient and other unit still paid on costs.
  - Outpatient costs overstated by 15-20%.
  - Hospital-based SNFs have costs 50% higher than freestanding SNFs

Hospitals' Inpatient Margins



Source: Medicare Payment Advisory Commission

“Excess” Growth in $/Person Resumes After Hospitals Learn



Source: Centers for Medicare and Medicaid Services

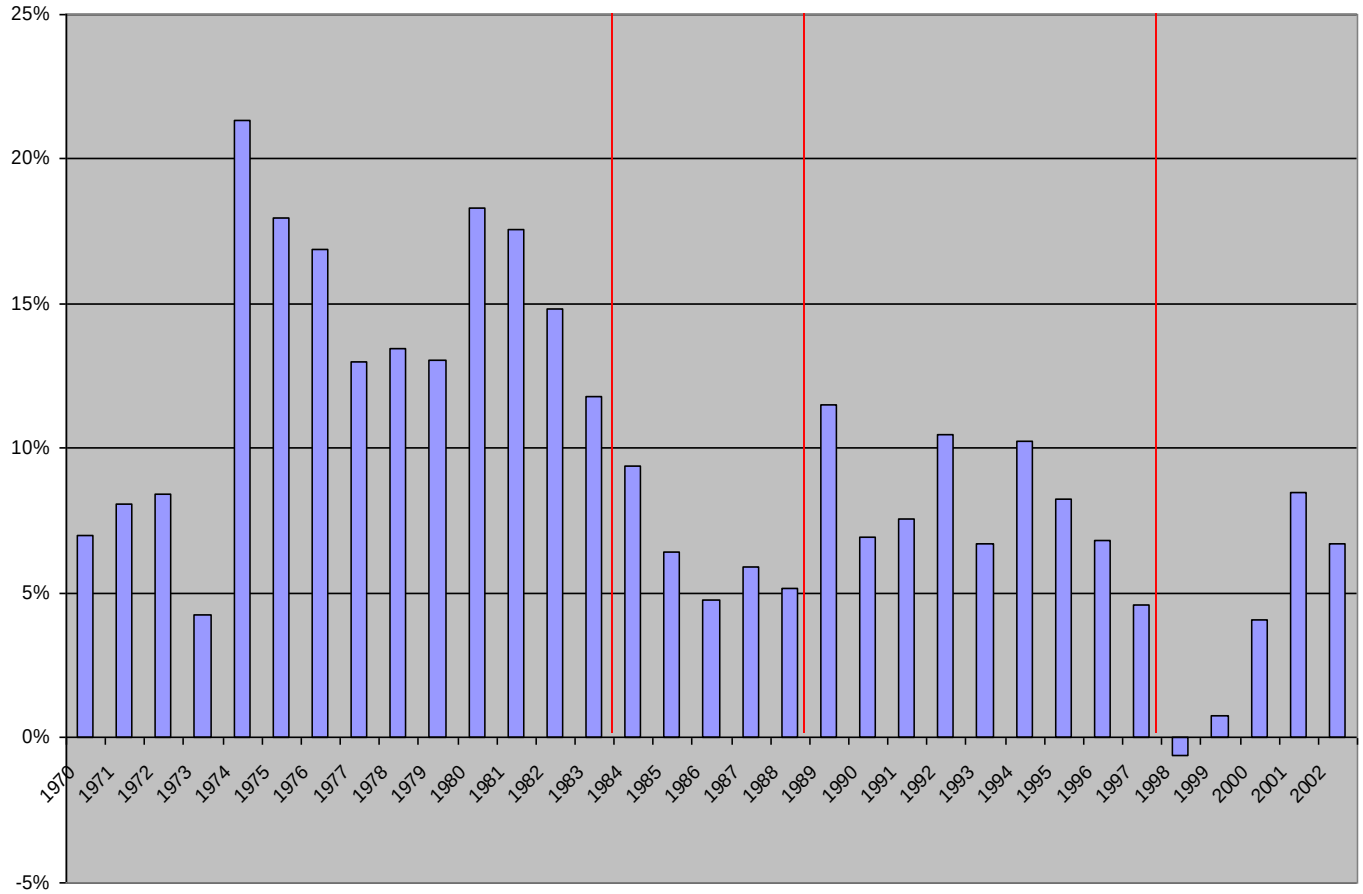
Prospective Payment Beyond DRGs

- Two decades after its inception, Medicare implemented DRGs for inpatient hospital services. Prospective payment has since been extended program-wide.
- Fee schedule for physician services implemented 1992.
  - Sustainable growth rate system enacted 1997, still needs annual "fixing"
- Partly to address the hospitals' unwanted responses to DRGs, and partly because broader reform is politically unpalatable, Congress in 1997 mandated prospective payment be put in place for:
  - Skilled nursing facilities (1998)
  - Inpatient rehabilitation facilities (1999)
  - Hospital outpatient departments (2000)
  - Home Health Agencies (2001)
  - Long-term hospitals (2002)

Experience with New Systems

- Too soon to evaluate, but results are not completely encouraging.
- The physician fee schedule was successful in controlling per-service costs, but had no impact on volume.
- The hospital outpatient PPS has been plagued by grouping of services whose costs diverge widely, inability to accommodate new technology.
- The PPS for SNFs was put in before Medicare had a reasonable way to classify patients and calculate relative values.
- The home health PPS was hampered by the fact that there is no obvious unit of payment. Medicare arbitrarily chose an episode of 60 days, but has no idea how many visits it should be buying.

Growth in Medicare $/Person, 1970-2002



Source: Centers for Medicare and Medicaid Services

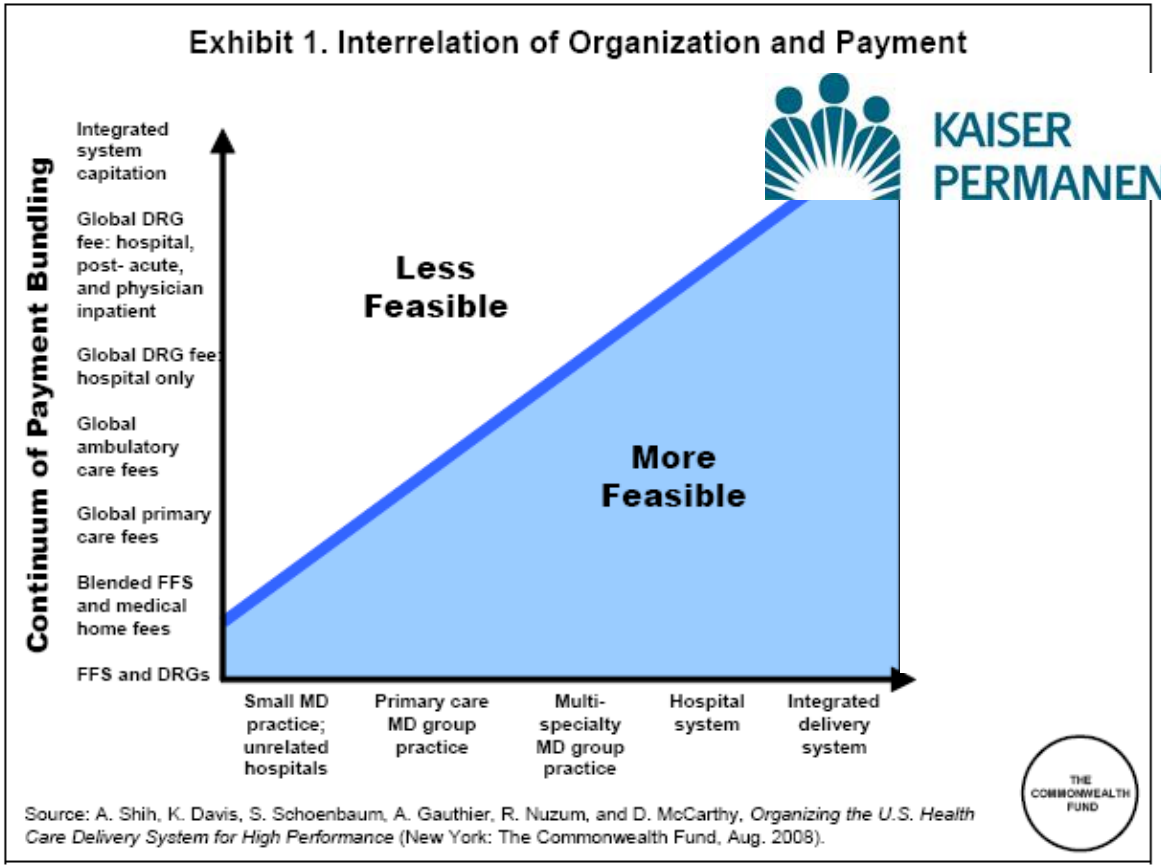
Conclusions

- Prospective payment is a framework, not a panacea.
- There is no "autopilot." Decisions must be made on an ongoing basis.
  - It helps, therefore, to have goals. For Medicare, it's maintaining access to care comparable to private insurance at the lowest possible cost.
  - Need to adjust payments to capture savings; by themselves, DRGs and other classification schemes save nothing.
- Need well-specified unit of payment and appropriate classification schemes.
  - If you don't know what you're buying, how can you know what to pay?
- Providers move faster than policymakers.
  - If there's a loophole, providers will find it.
  - Don't gain much if you control price and providers control volume.

Appendix: Select Medicare Payment Systems

	Acute inpatient hospital	Physicians	Outpatient Hospital	Skilled Nursing Facility	Home Health Agency	Medicare Advantage
Year began	1984	1992	2000	1998	2001	1998
Unit of payment	Discharge	Service	Service	Day	60-Day Episode	Month
Classification	500+ DRGs	7,000+ HCPCS codes	HCPCS grouped into 750 APCs	44 RUG-III groups	80 HHRGs	Enrollees' demographic and health status
Relative values						
Components	1 per DRG	work, practice expense, liability	1 per APC	therapy services, nursing care	1 per HHRG	1 per Enrollee Category
Source	billled charges	judgement, practice expense data	median of estimated costs	staff-time studies	mean of estimated costs	FFS costs 1992-1996
Initial base rate	updated 1982 costs	spending in prior system	updated 1996 costs	spending target	spending in prior system	historical spending
Payment adjustments						
Input Prices	hospital wage index	GPCI	hospital wage index	hospital wage index	hospital wage index	hospital wage index
Other	low-income patients, teaching costs		None	None	None	
Update method	Market Basket	Formula	Market Basket	Market Basket	Market Basket	Formula

Policymakers have a map …



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