Federal Health Care Issues Related to Older Persons

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Lecture Outline

• Share of Nation’s health dollars for older persons (c. 33%)
• Where expenditures go
• Medicare reimbursement: PPS
• Managed care vs. Fee for Service
• MMA, 2003
  – Prescription drugs
  – Chronic care improvement
  – Pay for performance
  – Information technology
Medicare, Medicaid, and SCHIP account for one-third of national health spending.

Total National Health Spending = $1.3 Trillion

1 Other public includes programs such as workers’ compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and State and local hospital subsidies and school health.

2 Other private includes industrial in-plant, privately funded construction, and non-patient revenues, including philanthropy.

Note: Numbers shown may not sum due to rounding.

Where the Medicare Dollar Went: 1980 and 2005

Medicare spending has moved from inpatient hospital services to all other settings. Managed care has grown while the physician share declined.

1 Other services include other professional services and ambulance services.
Note: Data do not sum due to rounding. Spending includes benefit dollars only.

Source: CMS, Office of the Actuary, Trustees Report 2006
Over twenty-two percent of state total spending and over forty-four percent of federal funds provided to states were spent on Medicaid.
Definition of Prospective Payment Systems

• A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.
• The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).
• CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

From CMS website
Issue: Medicare reimbursement policies

- Physician payments
  - RBRVS

- Hospital
  - PPS (DRGs) 1983

- Skilled nursing home
  - PPS 1999

- Home health
  - PPS 2000

- Hospice
  - FFS, per visit or service
Issue: Hospital payments

- DRGs
  - Effect on length of stay
  - Rise in sub-acute care, skilled nursing care
- Maryland’s unique all-payer system
- Pay for Performance (P4P) based on quality indicators
Issue: Physician payment

• Physician payment: 17% of Medicare costs in 2005
• Physician fee schedule
  – Relative value units
  – Has it worked? MEDPAC
• Revenue from Medicare c. 20%
RBRVS (Relative value units)

- Attempt to control rise in cost of procedures and stagnation in payments for non-procedural events
  - amount of work required to provide a service
  - expenses related to maintaining a practice
  - liability insurance costs
Issue: Managed care vs. fee for service

- 20% of Medicare beneficiaries in MA plans
- Advantages and disadvantages
  - Integrated care
  - Risk as incentive to HMO to prevent disease
  - Payment for HMOs
    - CMS adjustments (claims-based risk adj)
    - Overpayment for MAs?
  - Medicare private fee-for-service plans
**Issue: Out-of-Pocket Expenses for Medicare Beneficiaries**

*Beneficiaries without supplemental insurance and those with Medigap coverage have higher out-of-pocket spending than other groups.*

Bar chart showing per capita dollars by type of insurance coverage for 2003.

- **Medicare FFS Only**: $4,673
- **Medigap**: $4,324
- **Other**: $3,950
- **Employer Sponsored Plan**: $3,957
- **Medicaid**: $2,776
- **Medicare Risk HMO**: $2,977

*Note: Premium payments are included*

*Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS), 1993 and 2003 Cost and Use Files.*
Other issues: MMA 2003

- Prescription drugs
- Chronic care improvement
- Linking quality with performance
- Information technology
Pay for Performance (P4P)

- Payment linked to whether quality indicators were achieved
- Who defines quality?
- CMS demonstrations in hospital care, physician providers
  - HaH Health Care Quality Demonstration Waiver