# Structuring Hospital and Physician Payment: Policy Options

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# Focus of Presentation

- Not the overall level of payment
- Structure of payment
  - Relative payments for different services
  - What aspects of a service are paid for
  - Unit of payment

# Consistent Policy Goal: Neutrality

- Provider financial incentives should not favor some treatment approaches over others
  - Providers should be equally well/poorly rewarded for any covered service
  - Allow patient needs to determine treatment
- Hospital payment
  - Attempt to base on relative costs
- Physician payment
  - Concept of physician work
  - Practice and malpractice costs

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# Deviations from Neutrality Increasingly Problematic

- Greater responsiveness by providers
  - Impressions from past
  - Today’s environment
    - Specialty hospitals
    - Physician-owned ambulatory facilities
    - Ancillary services in physician offices
    - Hospital investment priorities
- Physician self-referral incentives

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# Sources of Payment Distortions (1)

- Differential trends in productivity
  - Newer technologies tend to have faster productivity gains
    - Declining costs of equipment
    - Physician and staff learning by doing
    - Devices to speed care
- Charge-based payment methods
  - Charges do not maintain a constant relationship to costs
    - At a point in time
    - Over time
  - Little incentive to providers to set charges carefully

# Sources of Payment Distortions (2)

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- Cost-based payment methods
  - Need for accurate baseline cost data
    - Unrealistic assumptions for equipment usage
  - Need for an effective update process
    - CMS data gathering very infrequent
      - Resources highly constrained
    - RVS update process lacks advocate for reductions

# CMS Proposed Reform of Inpatient Payment Rates (1)

- Two distinct changes
  - DRG weights more accurately reflect relative costs
  - Use of APR DRGs to better adjust for patient severity
- Services paid less
  - 558 PTCA
  - 104 Cardiac valve
  - 076 Other respiratory system O.R. procedures
- Services paid more
  - 087 Pulmonary edema and respiratory failure
  - 174 G.I. hemorrhage

# CMS Proposed Reform of Inpatient Payment Rates (2)

- Hospitals with negative impact
  - Heart and orthopedic hospitals
  - Major teaching
  - Small urban
  - East South Central region
- Hospitals with positive impact
  - Disproportionate share
  - High Medicare caseloads
  - Pacific region

# Proposed Rule for Physician Payment

- Recommendation from RUCC
- Sharp increase for evaluation and management services
- Problem with old data on practice expense
  - Hazards of mixing new specialty surveys with older data
- Specific issues in technical component of payment for imaging
  - CMS cost assumptions

# Blending Update Process with Restructuring Payment

- Using volume trend as signal to reduce relative values
  - Increasing volume as indicator of payment distortion
  - Increasing volume as indicator of technology-driven change

# Longer-term Payment Policy Options

- Pay for performance
  - Hospitals
  - Physicians
  - Challenges
    - Pay for performance that is meaningful
    - Blend rewards for high versus improving performance
- Payment for e-visits or telephone calls
- Payment for care coordination
- Payment by episode
- Capitation

# Is There a “Competitive Alternative” to Administered Prices?