Health care funding / reimbursement in the U.S. – part 1

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Medical Student Business Development Lecture
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“Business of Medicine”
learning opportunities

• Noontime talks
  – Topics include reimbursement, marketing, revenue cycle, contracts

• Healthcare reform forum
  – 4-session discussion series in the fall & spring

• Administrative internship between 1st and 2nd years
“Business of Medicine”
learning opportunities

• Future directions:
  – 4th year elective
  – Integration into curriculum

• Your ideas are welcome!!
What we’ll talk about

• Provide an overview of how our current payment system evolved in early to mid 1900s

• Define general terms related to reimbursement
Outline

• Historical info (pre-1970):
  – History of autonomous physicians receiving FFS-type payments
  – Rise of the employer-based system
  – Medicare & Medicaid

• Current time (post-1970):
  – How hospitals & physicians paid

• Part 2 – focus on newer models of payment & PPACA / ACOs – November 28th
Why are we talking about this?

Medical spending as a % Gross Domestic Product – Congressional Budget Office
## Current healthcare spending statistics

<table>
<thead>
<tr>
<th>Country</th>
<th>Infant Mortality</th>
<th>Life Expectancy</th>
<th>Per Capita Expenditures</th>
<th>% GDP Spent on Healthcare</th>
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</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>2.8</td>
<td>80.6</td>
<td>$3,202</td>
<td>9.2%</td>
</tr>
<tr>
<td>Japan</td>
<td>3.2</td>
<td>81.4</td>
<td>$2,474</td>
<td>8.2%</td>
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<tr>
<td>Germany</td>
<td>4.1</td>
<td>79.0</td>
<td>$3,371</td>
<td>10.6%</td>
</tr>
<tr>
<td>Canada</td>
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<td>80.3</td>
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</tr>
<tr>
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<td>78.7</td>
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<tr>
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<tr>
<td>United States</td>
<td>6.4</td>
<td>78</td>
<td>$6,714</td>
<td>15.1%</td>
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</tbody>
</table>
In the beginning...

• mid to late 1800’s – highly fragmented, multiple training pathways

• Quality variable

• Method of payment generally individually negotiated

• Germ theory of disease emerged
Flexner report

• Published in 1920 and established standards for medical education

• Hospital was key site of training

• Number of “medical schools” dropped

• State licensure came into being
Physician / hospital relationship

• Many physicians not affiliated with hospitals
  – Clash between staff and private physicians

• With paying patients entering, physicians started to be able to charge

• Staffs opened up with financial pressures
Lack of integration / struggle for control

• Non-academic hospitals courted independent medical staff

• “public health” historically controlled by non-physician entities
  – Physicians strongly opposed these
Employers

• Much employer-based care started in industrial companies requiring injury care
• Health care used to build loyalty – “welfare capitalism”
• Workers generally disliked employment models
• Court rulings preventing corporate practice of medicine
Early 1900’s:
Establishment of payment model

- Development of independent, autonomous physicians being paid transactionally

- Self-reinforcing cycle as physicians had increasing professional cohesion and political clout
Europe - Social insurance

• Compulsory “sickness insurance” in late 1800s, subsidized
  – Part of larger social insurance movements
• US govt largely decentralized / strong state medical societies
• Division between public health & physicians
• Labor unions opposed
• Defeat of US efforts – first in 1910’s
1920 – 1930:
Idea of insurance gains traction

- Physician & hospital costs increasing
  - Scientific advances + increasing power
- Backdrop of depression
- Some type of insurance seen as needed
  - Nation strategy opposed by AMA, seen as socialism, failed gaining traction as part of social security, public health even more fractured
  - VA system started
  - Well off or well-organized looked for other options
Private insurance

• Grew with defeat of national efforts
  – Indemnity plans
  – Service benefits

• Blue cross plans started late 1930s
  – Local history in Texas

• Physicians held line on not bundling with hospitals – Blue shield started ~ 1940
Employer insurance

• Union growth / Collective bargaining legal with New Deal

• Way to work around WWII price controls

• Medical care became bargaining chip

• “Voluntary” health insurance promoted by AMA

• Federal government began providing in 1960
AMA

• Founded in mid-1800’s

• Played critical role in maintaining physician independence
  – Opposed anything that would have undermined autonomy

• Often more conservative as an organization than its members

• Walks a difficult line advocating for all specialties
Medicare

• Started in 1965
• Funded through payroll tax
• In addition to eligible persons over 65, the following are eligible for Medicare:
  – Patients with disability on SSI >24 mos
  – ESRD on dialysis
  – Disability with AML
• Funds most residency training
• Administered by HCFA -> CMS
Medicare

• 4 parts:
  – Part A – hospital insurance
    • 100 days skilled nursing inpatient
  – Part B – medical insurance
  – Part D – prescription drug coverage – started 2006
Medicaid

- Also authorized in 1965
- Initially completely separate – joined in 1977
- Jointly funded by states and federal govt
  - Administered by states
  - Govt monitors and sets minimum standards
- Income based + other eligibility
  - Age (children – includes dental)
  - Pregancy
  - Disability (includes AIDS)
  - Citizen / permanent resident
- SCHIP programs – created 1997
Summary of major points thus far...

• Physician practice initially fragmented
• Hospitals started as a location for charity care
• Efforts for nationalized insurance defeated
• Employer-based insurance the predominant model
• Fee for service reimbursement dominant
• Hospitals & physicians paid separately for care
How things work under our current FFS model
Fee for service

• Payments given for single episodes of care

• Physicians must have face-to-face interactions to bill
Physician services - CPTs and RVUs

• **CPT** - Current procedural terminology
  – Most widely used medical nomenclature system
  – assigns a code to any procedures and services

• **RVU** – Relative value unit
  – Created in 1985 by Physician Payment Review Commission
  – Assigns “workload” value based on resources and costs required to provide services
    • (physician, practice, malpractice components)
  – Adopted by HCFA in 1992
  – Examples:
    • Detailed office visit – new pt – CPT 99203 wRVU 1.34
    • L sided cardiac cath – CPT 93510 wRVU 4.33
CPTs and RVUs

• A CPT has associated RVUs – physicians are paid according to the associated wRVUs

• A physician submits an invoice to payors with a CPT code -> these are converted to RVUs
Balanced Budget Amendment

• Passed in 1997 under Clinton administration
• Introduced **sustainable growth rate** (SGR) for Medicare
  – Idea that Medicare expenditures would not exceed GDP growth
  – To counteract increase in volume of services, reimbursement would decrease
  – Current required conversion factor would be >21%
    • Cardiology example
  – Congress has enacted provisions to put off SGR conversion, but has not addressed underlying issue
Independent Payment Advisory Board

• Panel of 15 physicians and patient advocates nominated by president and confirmed by senate

• Would recommend policies to “help Medicare provide care at lower costs.”

• Congress can accept or reject recommendations

http://www.whitehouse.gov/blog/2011/04/20/facts-about-independent-payment-advisory-board
Diagnosis-related groups

• Previously hospitals reimbursed based on costs
• Goal of DRG explicitly to change hospital behaviors through reimbursement
• Created in 1980 – pilots in NJ
• Medicare adopted in 1983
• Some care still provided on a cost basis
  – Transplant
  – “outliers”
Outpatient diagnostic / procedure services

- Have professional and technical components
- Professional = physician evaluation
- Technical = supports the actual performance of the service
- Payments may be global or separate depending on the service
From the patient’s perspective...

• Multiple bills!

• Often confusing who is charging for what
From the payor’s perspective

• Must have separate infrastructure for physician and facility billing
Managed Care

• General term used to describe any technique to reduce costs
  – (and usually to improve quality)

• Types:
  – HMOs
  – IPAs
  – PPOs
  – POS
Health Maintenance Organizations

• Covers care provided only by a proscribed network in accordance with HMO guidelines
  – PCP typically acts in a “gatekeeper” function

• HMO Act of 1973 – required employers with >25 employees to offer HMO options

• Typically capitated payments - Staff model, group model, network model

• Increased presence as a model in the 1990’s
Preferred Provider Organizations

• “fee for service delivery system”
• Providers offer discounts to have access to larger pools of patients
• Explicitly contract with cost-effective providers and conduct ongoing utilization review
• PPO can contract with physicians or hospitals
IPAs / PPOs / POS

• IPA – Independent practice association
  – group of physicians that may contract with an HMO to provide services
  – Typically not exclusive

• PPO – preferred provider organization
  – Membership group in which participating physicians offer a discount
  – Charges an access fee

• POS – point of service plan
  – Access to any provider, but increased costs for moving away from networked providers
Health Savings Accounts

• HSAs authorized as part of MMA in 2003
• Tax-advantaged savings account
• Coupled with high-deductible plans – the HSA gives a tax benefit to the dollars saved to cover costs
• Goal was to increase consumer involvement in decisions around health care costs
Summary of key points on FFS system

• All parties bill separately
• Physicians reimbursed based on CPTs -> RVUs
• Hospitals reimbursed based on DRG
• Outpatient services have professional & technical component

• Lots of fragmentation
Pay for performance (P4P)

- Idea of paying for outcomes
- Layered on to current reimbursement models
- 2003 – CMS Premier program
  - Focuses on AMI, CHF, CAP, CABG, joint replacement
  - Top and second deciles receive 2%, 1% increased payment
  - 9th and 10th deciles receive 1%, 2% lower payment in year 3
Longer term outcomes

• **No significant change** in outcome improvement for P4P conditions versus other conditions

• **No significant change** for participating hospitals versus non-participating hospitals
P4P - challenges

• For this to work, need:
  – Agreement on outcomes
  – reliably measurable outcomes

• Cost of participation
  – IT infrastructure
  – Clinical data abstraction

• What do to about small numbers

• Unintended consequences:
  – Will providers stop caring for sick patients?
Patient-centered medical homes

• An approach to providing comprehensive care
  – Partnership with patient
  – Provide care coordination
• Brings in focus on population health
• Endorsed by AAFP, AAP, ACP, AOA
• Medicare demonstrations began 2006
  – Harvard example
Bundling

• One payment made for episodes of care
  – Physicians and hospitals must divvy up payments between them
  – Overall reimbursement typically lower than separate reimbursement, but coordination between hospitals & physicians leads to cost reduction

• Medicare demonstration projects 2009
  – Baptist example
Accountable Care Organizations

• Builds on move from separate episodic payments to reimbursement based on total costs / overall health of population
• Combines financial bundling with quality / outcomes payments
• Will require coordination across spectrum of care
• Medicare has a number of ACO pilots ongoing
Role of Medicare

• Medicare sets thresholds for what is reimbursed
  – Quality-adjusted life-year (QALY)

• Medicare pilots new reimbursement models

• Medicare Center for Innovation 2010 – allows for expansion of successful pilots
Summary timeline

• Late 1800’s – fragmented
• Early 1900’s – Flexner report, beginning of consolidation of MD autonomy, rise of AMA
• 1910’s – 1930’s – failure of compulsory insurance
• 1940’s – 1950’s – rise of unions, employer-based insurance
• 1965 – Medicare / Medicaid
• 1973 – HMO Act
• 1983 – Medicare adopts DRG system
• 1986 – RVU system created, public reporting began
• 1997 – Balanced Budget Amendment, SCHIP programs authorized
• 2003 – Medicare modernization act (HSAs created), Medicare P4P
• 2006 – Medicare PCMH projects
• 2008 – 2009 – Medicare bundling projects
• 2010 – Affordable Care Act, Medicare Center for Innovation
In summary

• Early history of reimbursement centered around growth of powerful, autonomous physicians providing services to individual patients

• Since 1970, other models of reimbursement considered – accelerating move towards models that account for quality and outcomes as well as cost containment
Resources

• The Social Transformation of American Medicine – Paul Starr
• CMS website
• http://www.ssa.gov/history/corning.html
• Resource-based Relative Value Units: a primer for academic family physicians
• http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home
Thank you!

Questions?