IMPROVING MEDICARE PAYMENT POLICIES

Medicare is the largest single purchaser of health care in the United States, so any policy implemented by the program has widespread effects on patients and providers. RAND’s work on Medicare payment policies has played a major role in improving payment systems, helping to better align incentives for providers and promote delivery of high-value care for patients.

**RAND found that efforts to control the cost of hospital stays meant that patients were being discharged “quicker and sicker.”**
Sharp increases in Medicare costs for hospital stays in the early 1980s drove the federal government to revise how Medicare pays hospitals for treating patients. The new fixed-price prospective payment system was effective at curbing cost growth and did not decrease quality of care, but RAND researchers found that patients were more likely to be discharged in an unstable condition, doubling their risk of death within 90 days of discharge. RAND’s work led to greater emphasis on discharge planning and increased the level of attention paid to the link between instability at discharge and hospital readmissions.

**RAND discovered that payment reforms for postacute care had unintended reimbursement consequences.**
Many medical facilities, including rehabilitation hospitals, provide postacute care. When RAND researchers helped the federal government assess the prospective payment model in these settings, they found that spending for relatively severe cases increased. RAND discovered that, under the new system, facilities were qualifying for higher reimbursement rates by more thoroughly coding patient conditions. To account for this change, Medicare took steps to adjust the baseline payment provided to inpatient rehabilitation facilities.

**RAND determined that the prescription drug benefit “doughnut hole” decreases medication adherence among seniors.**
In 2002, Medicare was the only large health insurance carrier in the United States that did not include a benefit for outpatient prescription drugs. The cost of different proposals to add this benefit was widely debated until RAND researchers published estimates for three alternative plans. The plan that Medicare implemented resembled one of those alternatives but left a gap between the $2,000 initial coverage limit and the $4,000 catastrophic threshold. RAND researchers found that prescription adherence dropped among seniors when they reached this “doughnut hole”—a breach that the Affordable Care Act will fully phase out by 2020.

**RAND predicted that the biggest driver of cost growth for Medicare would be expensive technological advances rather than an aging population with chronic diseases.**
The federal government asked RAND to identify drivers of future Medicare expenses in response to concerns that population aging would significantly increase costs. RAND researchers developed a model that predicts how technological advances and the health of future generations of beneficiaries will influence Medicare spending. They found that expensive technological advances that improve health will be the most significant factor driving overall health care cost increases, and that investments in preventing and treating any single chronic disease—with the exception of obesity—would only modestly reduce Medicare’s future costs.

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