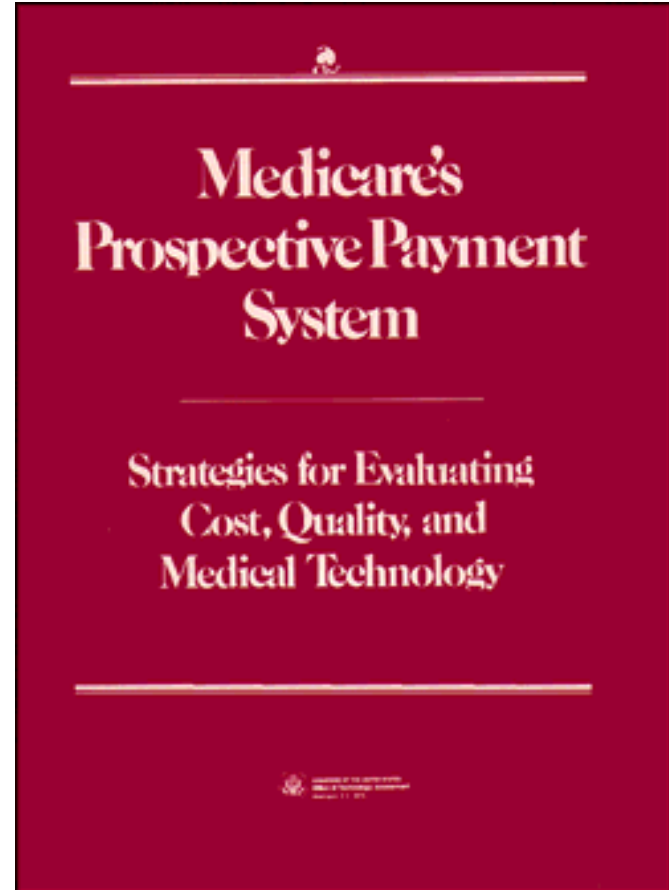


*Medicare's Prospective Payment System:
Strategies for Evaluating Cost, Quality, and
Medical Technology*

October 1985

NTIS order #PB86-184926



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Foreword

Twenty years ago, Congress made a major commitment to securing older Americans' access to acute medical care with the creation of Medicare. Subsequent legislation extended the Medicare program to disabled people and to victims of end-stage renal disease. Medicare has been an unquestioned success in reducing financial barriers to health care for its beneficiaries, but the program's costs have risen rapidly.

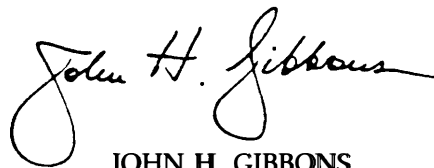
Medicare's payment methods have discouraged doctors, hospital managers, and patients from making cost-effective decisions regarding the use of medical technology. Retrospective cost-based hospital reimbursement was particularly troublesome and, most would agree, inflationary.

Congress ended cost-based reimbursement for inpatient hospital care for Medicare beneficiaries with the creation of Medicare's prospective payment system (PPS) in 1983. The new hospital payment system has reversed the financial incentives away from the provision of more care for hospitalized patients to the provision of less care. Now, the Nation needs to know what this radical change in financial incentives is doing to the quantity and quality of health care received by Medicare beneficiaries, and to the effectiveness of Medicare resources.

Early in 1984, two committees of Congress, the Senate Committee on Finance and the Senate Special Committee on Aging, asked OTA to conduct an assessment that would identify potential economic and health-related effects of PPS and develop a series of strategies for an evaluation of the most important effects.

In this report, OTA arrays the possible effects of PPS on the health care system and assesses the extent to which these effects can be measured. Potential PPS impacts are summarized, and critical evaluation questions are identified for each impact area. In addition to identifying specific studies that would address the critical evaluation questions, OTA also attempted to put the studies in a priority order, based on their cost and feasibility.

OTA was guided in the study by an advisory panel chaired by John Eisenberg. Drafts of the report and several working papers prepared as background were reviewed by members of the advisory panel, members of the OTA Health Program Advisory Committee, and other experts in the Federal and State governments and in health policy research. We are grateful for their assistance. Key OTA staff were Judith Wagner, Anne K. Burns, Mary Ann M. Hughes, Cynthia P. King, and Elaine J. Power.



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List of Related OTA Reports

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