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ABF Information Series Number 3. Lessons from the USA

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Abstract

The USA was the first country internationally to fund hospital inpatient services under an ABF model. The US model has been refined over many years and, given this longer experience, it is worth briefly summarising some of its key features.

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ABF Information Series No. 3

Lessons from the USA

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The USA was the first country internationally to fund hospital inpatient services under an ABF model. The US model has been refined over many years and, given this longer experience, it is worth briefly summarising some of its key features.

The US payment system for Medicare patients is called the inpatient prospective payment system (IPPS). It is managed by the Centers for Medicare and Medicaid Services, US Department of Health and Human Services.

Under the IPPS, each case is classified by Diagnosis Related Group (DRG) and each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. This is the same approach that is used in Australia.

Unlike Australia, the base payment rate is divided into a labour-related and non-labour share. The labour-related share is adjusted by the wage index applicable to the area where the hospital is located. This is important because, as in Australia, salary rates vary around the country and are not controlled by federal awards.

If the hospital is located in either Alaska or Hawaii, the non-labour share is adjusted by a cost of living adjustment factor. This recognises the higher cost of delivering health care in those States. Australia has, of course, similar issues but this approach is not built into existing Australian ABF models in any systematic way.

If a hospital treats a high-percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payment for hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients.

If more than 15% of hospital patients are low-income (socially disadvantaged), the hospital is eligible for a DSH payment adjustment based on another statutory formula. The formula varies for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, hospitals that qualify as rural referral centers or sole community hospitals, and other hospitals.

There is provision for New Medical Services and New Technologies payments where it can be demonstrated that the DRG prospective payment rate does not adequately fund a new medical service or technology.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid through IPPS. This add-on, known as the indirect medical education (IME) adjustment, varies depending on the ratio of residents-to-beds under the IPPS for operating costs, and according to the ratio of residents-to-average daily census under the IPPS for capital costs. There are also Direct Graduate Medical Education (DGME) payments to hospitals for the costs of approved graduate medical education (GME) programs.

Finally, as in Australia, cases that are unusually costly (outlier cases) attract additional IPPS payments. These additional payments are designed to protect the hospital from large financial losses due to unusually expensive cases.

Rather than reinventing the wheel, there are important lessons that can be learned from the US experience in applying an ABF model at a national level in Australia.