CHAPTER 3

Assessing payment adequacy and updating payments in fee-for-service Medicare

RECOMMENDATIONS

Section A: Hospital inpatient and outpatient services

3A-1 The Congress should increase payment rates for the inpatient prospective payment system by the projected rate of increase in the hospital market basket index for fiscal year 2005.

COMMISSIONER VOTES: YES 14 • NO 0 • NOT VOTING 1 • ABSENT 2

3A-2 The Congress should increase payment rates for the outpatient prospective payment system by the projected rate of increase in the hospital market basket index for calendar year 2005.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

3A-3 The Congress should eliminate the outlier policy under the outpatient prospective payment system.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

Section B: Physician services

3B The Congress should update payments for physician services by the projected change in input prices, less an adjustment for productivity growth of 0.9 percent, in 2005.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Section C: Skilled nursing facility services

3C-1 The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2005.

COMMISSIONER VOTES: YES 16 • NO 1 • NOT VOTING 0 • ABSENT 0

3C-2 The Secretary should develop a new classification system for care in skilled nursing facilities. Until this happens, the Congress should authorize the Secretary to:

- remove some or all of the 6.7 percent payment add-on currently applied to the rehabilitation RUG–III groups.
- reallocate the money to the nonrehabilitation RUG–III groups to achieve a better balance of resources among all of the RUG–III groups.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

3C-3 The Secretary should direct skilled nursing facilities to report nursing costs separately from routine costs.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Section D: Home health services

3D-1 The Congress should eliminate the update to payment rates for home health services for 2005.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 1 • ABSENT 0

3D-2 The Secretary should continue to monitor access to care, the impact of the payment system on patient selection, and the use of services across post-acute care settings.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Section E: Outpatient dialysis services

3E-1 The Congress should maintain current law and update the composite rate by 1.6 percent for 2005.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 1 • ABSENT 0

3E-2 The Congress should establish a quality incentive payment policy for physicians and facilities providing outpatient dialysis services.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Section F: Ambulatory surgical center services

3F-1 There should be no update to payment rates for ASC services for fiscal year 2005.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

3F-2 The Secretary should revise the ASC payment system so that its relative weights and procedure groups are aligned with those in the outpatient prospective payment system. In addition:

- The Congress should require the Secretary to periodically collect ASC cost data at the procedure level to monitor the adequacy of ASC rates, refine the relative weights, and develop a conversion factor that reflects the cost of ASC services.
- The Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for the same procedures, accounting for differences in the bundle of services.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

3F-3 After the ASC payment system is revised, the Congress should direct the Secretary to replace the current list of approved ASC procedures with a list of procedures that are excluded from payment based on clinical safety standards and whether the service requires an overnight stay.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

CHAPTER 3

Assessing payment adequacy and updating payments in fee-for-service Medicare

In this chapter

- Hospital inpatient and outpatient services
- Physician services
- Skilled nursing facility services
- Home health services
- Outpatient dialysis services
- Ambulatory surgical center services

MedPAC makes payment update recommendations annually for fee-for-service Medicare. We use a framework to help us develop our recommendations in the most thoughtful and consistent way possible. The framework breaks the process into two parts: first assessing the adequacy of Medicare payments for efficient providers in 2004 and then assessing whether and how payments should change in 2005. When considering whether current payments are adequate, we also account for policy changes scheduled to take effect under current law. This year we make update recommendations in seven sectors: hospital inpatient, hospital outpatient, physician, skilled nursing facility, home health, outpatient dialysis, and ambulatory surgical center. Generally we found that current payments are at least adequate—and in some cases more than adequate—in these sectors.

The goal of Medicare payment policy is to align payments with efficient providers' costs of furnishing health care and in doing so maintain beneficiaries' access to high-quality services. Achieving this goal involves setting the base payment rate (for services of average complexity) at the right level, developing payment adjustments that accurately reflect cost differences among types of services and for varying market conditions and types of patients, and then annually considering the need for a payment update.

MedPAC makes payment recommendations for the major fee-for-service Medicare providers. Our general approach to developing payment policy recommendations attempts to:

- make enough funding available to cover the costs of efficient providers, thus maintaining Medicare beneficiaries' access to high-quality care, and
- correct payment inequities among services and providers.

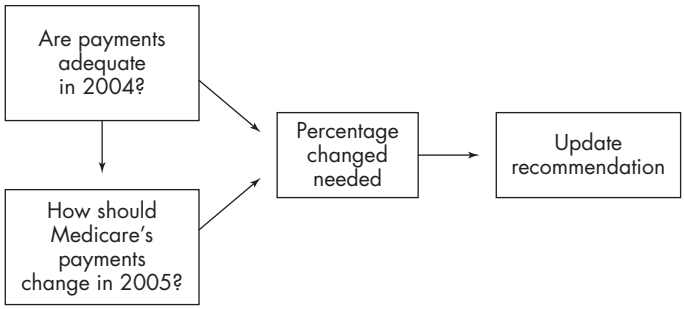
The Commission's annual update recommendations address the first of these objectives. In addition, we also make recommendations that address distributional issues. The update and distributional recommendations will often be coupled because meeting the goals of access to care and adequate payments may require distributional changes as well as updates.

MedPAC uses a framework to guide our update decision-making process in the most thoughtful and consistent way possible. In our model, we sequentially address two questions that together determine the appropriate level of aggregate funding for a given payment system:

- Are payments adequate for efficient providers in 2004?
- How should Medicare payments change in 2005?

In the first part of our adequacy assessment, we can recommend a percentage change factor if we judge that Medicare payments compared to efficient providers' costs are too high or too low in the current year—2004 (Figure 3-1). In the second part, we can recommend a percentage change in Medicare's payments based on how we expect efficient providers' costs to change in the next payment year—currently 2005. We may also consider changes in how the total pool of dollars in each sector should be distributed among providers in the next payment year and thereafter (if necessary). We then consider both parts of the model together to produce our recommended update.

FIGURE 3-1 **Framework for assessing payment adequacy and updating payment rates**



Our model separates assessing the adequacy of current payments from updating payments because commingling these processes has caused confusion in the past. For example, one of the factors the Commission believed was responsible for hospital payments being too high in the 1990s was unbundling of services during an inpatient stay—the unit of payment. Hospitals shifted care at the end of patients' acute inpatient stays to other settings, such as rehabilitation or skilled nursing facilities, thereby reducing hospitals' costs. The industry's response to the Commission's decision to recommend reduced updates was that the updates would not adequately cover hospital cost inflation. Separating the analysis of current payments from an analysis of cost growth in the coming year would have presented a clearer rationale for our recommendation by showing that current payments were more than adequate.

This section of the chapter reviews our two-part model. The chapter then proceeds through the Commission's analysis of payment adequacy and development of update and other recommendations for hospital inpatient and outpatient, physician, skilled nursing facility (SNF), home health, outpatient dialysis, and ambulatory surgical center services.

Are Medicare payments adequate in 2004?

The first part of MedPAC's approach to developing payment updates is to assess the adequacy of current payments. For each sector, we judge whether current Medicare payments are adequate by examining a broad array of information about:

- beneficiaries' access to care
- changes in the supply of providers
- changes in the volume of services
- changes in the quality of care
- providers' access to capital
- Medicare payments and providers' costs for 2004

Because the goal of Medicare payment policy is to align payments with efficient providers' costs of furnishing health care, and in so doing maintain beneficiaries' access to high-quality services, our measures are both beneficiary-focused (access to care and quality of care) and provider-focused (providers' access to capital and payments and costs for 2004). We consider multiple measures because the direct relevance, availability, and quality of each type of information varies among sectors, and no one measure provides all the information needed for MedPAC to judge payment adequacy.

Beneficiaries' access to care

In the absence of evidence showing widespread and systematic access problems, Medicare's payment rates could be at least adequate or too high. Whether Medicare's payments influence access to care will depend on the extent to which Medicare is the dominant payer for that service. It is important to bear in mind that factors unrelated to Medicare's payment policies, such as beneficiaries' preferences, supplemental insurance, and transportation difficulties, may also affect access to care.

The indicators we use to assess beneficiaries' access to care depend on the availability and relevance of information in each sector. For example, we assess physicians' willingness to serve beneficiaries and ask beneficiaries about their access to physician care. For home health services, we examine whether communities are served by providers and whether beneficiaries report they can obtain care.

Changes in the supply of providers

Rapid growth in the capacity of providers to furnish care may indicate that payments are more than adequate to cover providers' costs. Changes in practice patterns and technology, however, may also affect providers' capacity.

Substantial increases in the number of providers may also indicate that payments are more than sufficient to cover providers' financial needs, potentially leading to unnecessary services being provided. For instance, evidence that more physicians in private practice continue to accept new Medicare patients could suggest that Medicare's payment rates are at least adequate and potentially more than adequate. Facilities closing is the extreme opposite outcome, although it can be difficult to distinguish between closures that have serious implications for access to care in a community and those that have resulted from excess capacity. Moreover, if Medicare is not the dominant payer, changes in the number of providers may be influenced by other payers' payment policies.

Changes in the volume of services

Increases in the volume of services could suggest that Medicare's payment rates are too high.[1] Conversely, reductions in the volume of services may indicate that revenues are inadequate for providers to furnish the same level of services. Either trend also could be explained by other factors, such as incentives of the payment system, changes in disease prevalence among beneficiaries, technology, practice patterns, and beneficiaries' preferences.

Changes in the quality of care

In the absence of evidence showing declines in the quality of care, Medicare's payment rates could be either about right or too high. However, as in the case of access to care and Medicare payments, assessing the relationship between quality and Medicare payments may be difficult. Quality is influenced by many factors, such as beneficiaries' preferences and compliance, providers' adherence to clinical guidelines, and public reporting efforts. Also, the influence of Medicare's payments on quality of care may be limited when Medicare is not the dominant payer. Even when Medicare is not the dominant payer, however, the program's quality improvement activities can influence the quality of care for a given service. Finally, increasing payments may not be an appropriate response to quality problems, particularly for those sectors for which MedPAC judges payments to be adequate. Rather, as discussed in Section 3E and Chapter 4, MedPAC supports linking payment to quality to hold providers accountable for the care they furnish.

Providers' access to capital

Access to capital is necessary for providers to maintain and modernize their facilities and capabilities for patient care. An inability to access capital that was widespread

throughout a sector might in part reflect on the adequacy of Medicare payments. However, access to capital may not be a useful indicator of the adequacy of Medicare payments when providers derive most of their payments from other payers or other lines of business. For example, the majority of hospital and SNF revenues—70 percent in hospitals and 88 percent in SNFs—come from private sources (private health insurance) and other government payers (such as Medicaid). Finally, circumstances can occur within a sector that can discourage outside investment because of the actions of certain providers. For example, outside investment could be discouraged for providers who are subject to a high level of government oversight because of fraudulent billings to the Medicare program.

For both nonprofit and for-profit providers, we examine changes in bond ratings. Such changes may indicate that access to needed capital has deteriorated or improved, although the data are difficult to interpret because access to capital depends on more than just bond ratings. We also use indirect measures that can demonstrate providers' access to capital, such as increases in the acquisition of facilities by chain providers and spending on construction. Thus, a sector's volume of borrowing and overall level of capital expenditures may provide evidence of access to capital. For publicly owned providers, we can also monitor changes in share prices, public debt, and other publicly reported financial information.

Payments and costs for 2004

We estimate total Medicare payments nationally for the year preceding the one to which our update recommendation will apply. In this report, we are estimating payments and costs for 2004 to inform our update recommendations for 2005.

For providers who submit cost reports to CMS—hospitals, SNFs, home health agencies, and outpatient dialysis facilities—we also estimate total Medicare-allowable costs and assess the relationship between Medicare's payments and providers' costs. The relationship between payments and costs is typically expressed as a margin.[2] A margin is calculated as payments less costs divided by payments—conceptually, the share of revenue a provider keeps. Because the latest payment and cost report data available to us are from either 2001 or 2002, we must estimate the 2004 margin.

To estimate payments, we first apply the annual payment updates specified in law for 2003 and 2004 to our 2002 base numbers. We then model the effects of other policy changes that will affect the level of payments during this period. We also model policy changes—other than payment updates—that are scheduled to go into effect in the decision year (2005). This allows us to consider whether current payments would be adequate under all applicable provisions of current law. Our result is an estimate of what payments in 2004 would be if 2005 payment rules were in effect.

To estimate 2004 costs, we generally assume that the cost per unit of output will increase at the rate of input price inflation. As appropriate, we adjust for changes in product and productivity based upon our review of trends in key indicators.

Using margins

As noted earlier, we calculate Medicare margins for the following services: hospital, skilled nursing care, home health care, and outpatient dialysis. In most cases, we assess payment adequacy for the services furnished in a single sector and covered by a specific payment system (for example, SNF and home health services). When a sector provides services that are paid for in multiple payment systems, however, our measures of payments and costs for the sector may become distorted because of cross-subsidization and allocation of costs among services. Examples of this phenomenon are hospitals and outpatient dialysis facilities. In these instances, we assess, to the extent possible, the adequacy of payments for the whole range of Medicare services that the sector furnishes. For hospitals, we calculate an overall Medicare margin that includes payments and costs for the six largest Medicare services hospitals provide—acute inpatient, inpatient rehabilitation, inpatient psychiatric, outpatient hospital, SNF, and home health. For outpatient dialysis services, we assess aggregate payments and costs for services included in the prospective payment bundle and for services for which providers receive separate payments from Medicare, such as injectable drugs.

Total margins—which include payments from all payers as well as revenue from all nonpatient sources—do not play a direct role in MedPAC's update deliberations (see text box, p. 61). MedPAC believes that Medicare payments should relate to the costs of treating Medicare beneficiaries and our recommendations address a sector's Medicare payments, not total payments.

We reached this conclusion based on evidence suggesting that total margins are largely unrelated to Medicare

margins. For example, previous MedPAC analysis shows little relationship between hospitals' overall Medicare margins and their total margins (MedPAC 2003a). This finding is not unexpected because a variety of factors other than Medicare payment determine total margins. The factors include the amount of private sector business, the policies of the insurers with whom providers have contracts, Medicaid payment policy and the amount of Medicaid business, the amount of uncompensated care provided, and revenue earned from nonpatient care services, investment income, and donations. The lack of a consistent relationship between Medicare margins and total margins suggests that changes in Medicare's payment policies may not provide a reliable tool for addressing the total financial performance of a sector. In addition, accurately calculating a total margin is problematic because no one data source reports all revenue streams for a given provider and its related organizations (Kane and Magnus 2001).

We calculate a sector's Medicare overall margin to inform our judgement about whether total Medicare payments cover efficient providers' costs. To assess whether changes are needed in the distribution of payments, we calculate Medicare margins for categories of providers that are significant to Medicare's payment policies. For example, we calculate Medicare margins based on where hospitals are located (in large urban, other urban, and rural areas) and by their teaching status (major teaching, other teaching, and nonteaching). Last year, MedPAC found on average rural hospitals had worse financial performance under Medicare than their urban counterparts (MedPAC 2003b). This led us to recommend policy changes to improve payments to rural hospitals so that beneficiaries' access to care would be maintained.

Multiple factors can contribute to a gap between current payments and costs, including changes in the management and efficiency of providers, unbundling of the services included in the payment bundle, and other changes in the product (such as reduced lengths of inpatient hospital stays). Developing information about the extent to which these factors have contributed to the gap may help in deciding whether and how much to change payments.

Finally, MedPAC makes a judgment when considering the relationship between payments and costs. No single standard governs this relationship. Rather, the desired relationship between payments and costs varies from sector to sector and depends on the degree of financial risk faced by individual providers, which can vary over time. Thus, the Commission considers the relationship between payments and costs anew each year, one sector at a time.

Appropriateness of current costs

Our assessment of providers' costs and the relationship between Medicare's payments and providers' costs is greatly influenced by whether current costs approximate what efficient providers would be expected to spend in furnishing high-quality care to beneficiaries. Our assessment is also influenced by how accurately providers report cost data in cost reports and how often CMS audits cost reports.

To assess whether actual costs provide a reasonable representation of the costs of efficient providers, we examine trends in the average cost per unit of output and evidence of change in the product being furnished. Although it is nearly impossible to know whether costs are "efficient" in the absolute, the rate of change in unit costs at least provides some evidence of whether the initial level of appropriateness has been maintained. Other things being equal, we would generally expect average growth in unit costs to be somewhat below the market basket increase because of productivity improvements.

In addition, changes in product can have a major effect on unit costs. For example, substantial reductions in the length of or the number of visits in home health episodes would be expected to reduce the growth in providers' costs (inflation adjusted). Finally, another way we could assess the appropriateness of current costs is to examine the relationship between providers' costs and quality of care.

Accurate cost reports are important for determining appropriate costs. Current costs could be overstated and our margin calculations could be biased downward when data are obtained from unaudited cost reports. We know that for at least one sector—outpatient dialysis—some portion of reported costs were found to be unallowable after facilities' cost reports were audited (MedPAC 2002, MedPAC 2003b).[3]

The frequency, timeliness, and intensity of CMS's audits varies among sectors. Hospitals make up a large portion of the facilities selected for audit because of the magnitude of payments they receive for items and services outside of the inpatient prospective payment system (e.g., graduate medical education, organ acquisition costs). The Balanced Budget Act of 1997 requires that dialysis facilities be

audited every three years. Other facilities are also selected for audit primarily for items paid outside of prospective payment systems (e.g., bad debts). In addition, any provider can be selected for audit based on a random selection process. The intensity of each audit varies and ranges from a desk review of the provider's cost report—which can consist of determining whether reported costs exceed threshold amounts to identify unusual variances and questionable treatment of costs that may require additional review—to an onsite audit of a provider's records. As appropriate, MedPAC adjusts the costs reported by providers to reflect the findings of an audit (see Section 3E, page 178).

In addition, we suspect that the allocation of hospitals' costs among service lines is distorted in the Medicare cost report, which in turn affects sector-specific margin calculations. Through most of the 1990s, hospitals were paid prospectively determined rates for acute inpatient services, but they were paid on the basis of incurred costs (subject to some limits) for all other services. Hospitals thus had an incentive to allocate as much of their costs as possible to services other than acute inpatient, potentially resulting in an overstated inpatient margin and understated margins for other components. Hence, we use the overall Medicare margin when assessing the adequacy of hospital payments.

How should Medicare payments change in 2005?

The second part of MedPAC's approach to developing payment update recommendations is to account for expected cost changes in the next payment year. For each sector, we review evidence about the factors that are expected to affect providers' costs. One major factor is changes in input prices, as measured by the applicable CMS price index. For most providers, we use the forecasted increase in an industry-specific index of national input prices, called a market basket index. For physician services, we use a similar index, known as the Medicare Economic Index. Forecasts of these indexes are intended to approximate how much providers' costs would rise in the coming year if the quantity, quality, and mix of inputs they use to furnish care were to remain constant.

Several other factors may also affect providers' costs in the coming year:

- *Scientific and technological advances*—Many improvements in medical science and technology enhance quality and reduce providers' costs (or leave costs unchanged). No increase in Medicare's payment rates is needed to accommodate these changes because providers have a financial incentive to adopt them. For medical advances that both improve quality and increase costs, MedPAC can include an allowance in its update recommendation. When reaching this judgment, the Commission takes into account the design of the payment system and how Medicare pays for new technology. For outpatient dialysis services, for example, we judged that a positive allowance was not necessary because the costs of most medical advances are paid for outside of the prospective payment system (MedPAC 2003b).

- *Improvements in productivity*—The Commission believes that Medicare's payment systems should encourage efficiency and that providers should be able to reduce the quantity of inputs required to produce a unit of service by at least a modest amount each year while maintaining service quality. Consequently, we have adopted a policy goal to create incentives for efficiency and include an adjustment for productivity when accounting for providers' cost changes in the coming year. MedPAC's productivity goal is based on a 10-year average of the U.S. Bureau of Labor Statistics' estimate of economy-wide, multifactor productivity growth, which is currently estimated at 0.9 percent. Our approach links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare. Market competition constantly demands improved productivity and reduced costs from other firms; as a prudent purchaser Medicare should also require some productivity gains each year. Medicare should expect improvements in productivity consistent with the average realized by the firms and workers that fund it. Historically, providers who are under fiscal pressure slow their cost growth more than those facing less fiscal pressure (MedPAC 2004).

Update and distributional recommendations

MedPAC's approach to updating payments can result in a percentage change that determines the final update recommendation. Coupled with the update recommendation, we may also make recommendations concerning the distribution of payments among providers.

These distributional changes are sometimes, but not always, budget neutral within the payments we judge to be adequate.

The Commission is aware of—and we document in this report—how spending for each recommendation would compare with expected spending under current law. We develop rough estimates of the impact of recommendations relative to the current budget baseline, placing each recommendation into one of several cost-impact categories. In addition, we assess the likely impact of our recommendations on beneficiaries and providers. ■

Total margins

MedPAC considers the Medicare margin—the difference between Medicare payments and costs for services provided to Medicare beneficiaries expressed as a percentage of payments—as one factor in our assessment of payment adequacy. We can do this only for sectors with data on current Medicare payments and costs—hospitals, skilled nursing facilities, home health agencies, and outpatient dialysis facilities. Total margins—calculated by including payments and costs from all payers and revenues from all business ventures—do not play a role in MedPAC's judgement of payment adequacy because:

- They are largely unrelated to Medicare margins.
- Medicare policies cannot reliably address a sector's total financial performance.
- Increasing Medicare margins to offset lower margins of other payers could affect the judgments of other payers.
- They do not reliably measure a sector's overall financial health.
- Medicare's payments should not reward inefficient providers.

Total margins are largely unrelated to Medicare margins

Previous MedPAC research shows that for hospitals, at least, overall Medicare margins are not highly correlated with total margins (MedPAC 2003a). Using 1999 data, we concluded that hospitals with negative Medicare margins and those with positive Medicare margins were almost equally likely to have had positive total margins (Figure 3-2, p. 62). Specifically, we found that 65 percent of hospitals with negative overall Medicare margins had positive total margins, while 69 percent of hospitals with positive overall Medicare margins had positive total margins.

What explains the lack of a consistent relationship between Medicare margins and total margins? Lower rates of return from investment income, lower donations, and poor financial performance of other business ventures will all drive down total margins. In addition, for sectors in which the majority of patient-care revenues are not derived from Medicare—such as hospitals and nursing homes—other payers' payment policies will have a greater impact than Medicare's policies on overall financial performance. For example, 70 percent of revenues in hospitals and 88 percent in nursing homes come from other government payers (such as Medicaid) and private sources (primarily private health insurance but also out-of-pocket spending, in the case of nursing homes).

Medicare's payment policies cannot reliably address total financial performance

The lack of a consistent relationship between Medicare margins and total margins suggests that changes in Medicare's payment policies may not provide a targeted tool for addressing the total financial performance of a sector. As MedPAC's analysis showed, increasing Medicare payments for providers with low Medicare margins would help providers with low total margins but also would help providers with high total margins. The benefit of increasing Medicare payments to providers would be proportionate to their

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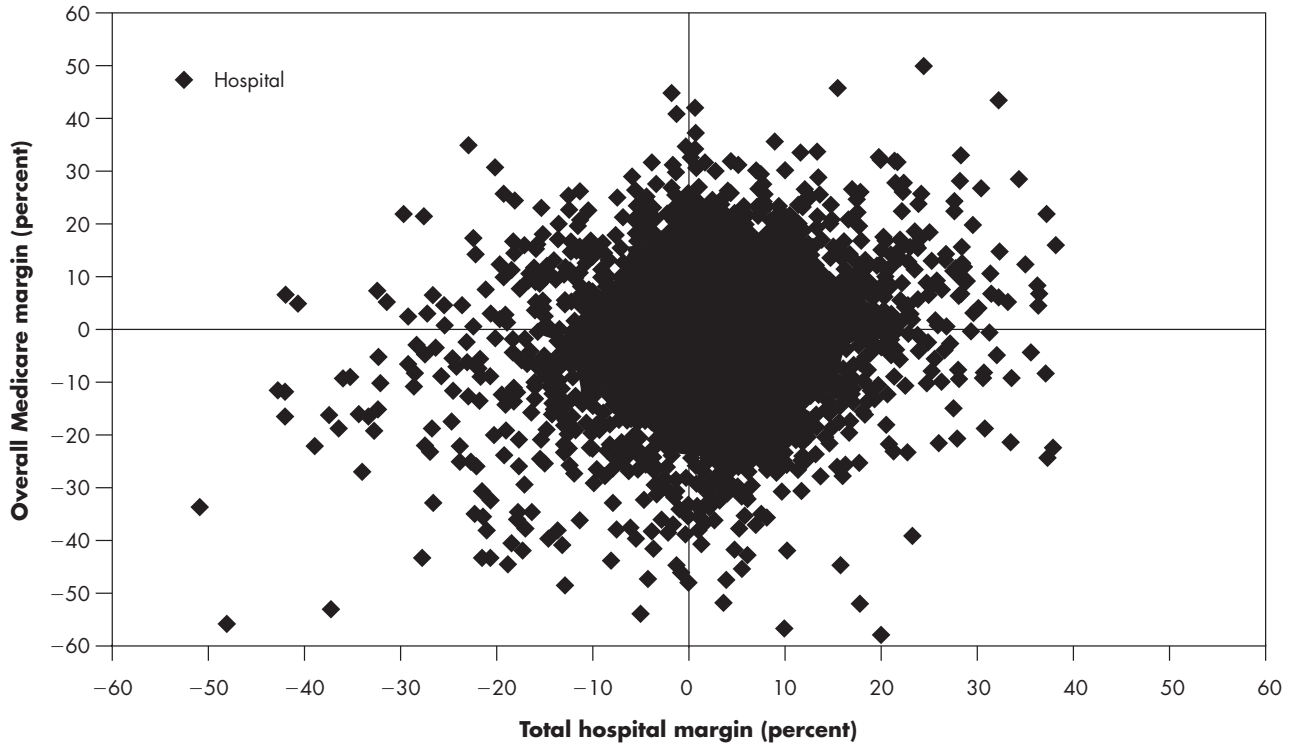
Total margins (continued)

FIGURE 3-2 **Relationship of overall Medicare and total margins, 1999**



Note: A margin is calculated as revenue minus costs, divided by revenue. Overall Medicare margin covers the costs and payments of hospital inpatient, outpatient, psychiatric and rehabilitation (prospective payment system-exempt), skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Total margin includes all patient care services funded by all payers, plus nonpatient revenues.

Source: MedPAC analysis of Medicare cost report file from CMS.

Medicare volume. Providers treating a lower volume of beneficiaries would not receive as much benefit from increasing Medicare payments as providers treating a higher volume of beneficiaries.

If Medicare were to offset reductions in the rates of other payers, this might encourage other payers to reduce their payments even more. This, in turn, could adversely affect providers who treat a higher proportion of non-Medicare patients, because they would:

- not benefit from increasing Medicare payments, and
- would be disproportionately hurt by any subsequent reduction in payments from other payers.

If this happened, Medicare's higher payments would not have their intended effect of improving the financial performance of a sector.

Finally, increasing Medicare payments to offset the lower margins by other payers might, in turn, affect the judgments of other payers about what services they pay for. For example, states enact certificate of need regulations to limit the supply of nursing home beds. Using Medicare to offset the decisions of others undermines the pluralistic nature of our system and will increase the program's costs.

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Total margins (continued)

Lack of reliable data to estimate total margins

Total margins derived from the Medicare cost reports may not be a good measure of a sector's overall financial performance. Kane and Magnus (2001) concluded that the information used to calculate total margins for hospitals is poorly defined and lacking in critical detail. Hospital cost reports were never intended to provide comprehensive data on hospital liquidity, solvency, profitability, or cash flows and thus offer limited financial accounting data about the sector's overall financial performance.

Other publicly reported data sources for this sector are also limited in their ability to assess overall financial performance. For nonprofit hospitals, some information about their revenues and expenses may be obtained from the returns these providers are required to file with the Internal Revenue Service (Form 990). However, this data source may not provide complete information about the revenues and expenses of affiliated organizations. And, in some cases, the affiliated organizations may not be clearly delineated.

Other sectors' cost report data may also be limited in their ability to reveal overall financial performance. Again, much of the difficulty stems from our inability to obtain information about all of the entities associated with a provider. For example, a recent filing with the U.S. Securities and Exchange Commission indicated that 47 percent of net revenues reported by a large nursing home chain were derived from pharmacy services, not from inpatient services. It is unclear how much a total margin derived from the cost reports for inpatient nursing home services would reflect this additional source of revenue.

Two additional points about the reliability of total margins are worth noting. First, it is not always possible to compare total margins across organizations, because different corporate structures lead to different accounting practices. Second, for strategic purposes, providers may decide to show negative total margins for a period of time. For example, Kane and Magnus (2001) noted that the liquidity position of a hospital may gradually deteriorate as it serves as a funding source for the other entities affiliated with it, such as physician practices, foundations, parent companies, and other ventures.

Medicare's payment policies should not reward inefficient providers

Increasing Medicare payments to offset low total margins of some poorly performing providers is a very costly and inefficient strategy. It also might discourage providers from becoming more efficient over time. The Commission believes that Medicare's payment systems should encourage providers to be efficient. The goal of Medicare payment policy is to align payments with *efficient* providers' costs of furnishing health care, and in doing so, maintain beneficiaries' access to high-quality services. ■

Endnotes

1 Changes in the volume of physician services must be interpreted cautiously because some evidence suggests that volume goes up when payment rates go down—the so-called "volume offset."

2 Alternatively, the relationship can be expressed as a ratio of payments to costs.

3 MedPAC's comparison of audited cost report data for 1996 with unaudited 1996 outpatient dialysis data showed that the allowable cost per treatment for composite rate services and injectable drugs for freestanding facilities was about 96 percent of the reported cost of treatment.

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