CHAPTER 2

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

RECOMMENDATIONS

Section 2A: Hospital inpatient and outpatient services

2A-1 The Congress should increase payment rates for the inpatient prospective payment system by the projected increase in the hospital market basket index less 0.4 percent for fiscal year 2006.

COMMISSIONER VOTES: YES 15 • NO 1 • NOT VOTING 0 • ABSENT 1

2A-2 The Congress should increase payment rates for the outpatient prospective payment system by the projected increase in the hospital market basket index less 0.4 percent for calendar year 2006.

COMMISSIONER VOTES: YES 15 • NO 1 • NOT VOTING 0 • ABSENT 1

2A-3 The Congress should extend hold-harmless payments under the outpatient prospective payment system for rural sole community hospitals and other rural hospitals with 100 or fewer beds through calendar year 2006.

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

Section 2B: Physician services

2B The Congress should update payments for physician services by the projected change in input prices less 0.8 percent in 2006.

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

Section 2C: Skilled nursing facility services

2C-1 The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2006.

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

2C-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, and
- 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 15 • NO 0 • NOT VOTING 0 • ABSENT 2

2C-3 CMS should:

- develop and use more quality indicators specific to short-stay patients in skilled nursing facilities,
- put a high priority on developing appropriate quality measures for pay for performance, and
- collect information on activities of daily living at admission and discharge.

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

Section 2D: Home health services

2D The Congress should eliminate the update to payment rates for home health care services for calendar year 2006.

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

Section 2E: Outpatient dialysis services

2E The Congress should update the composite rate by the projected rate of increase in the end-stage renal disease market basket index less 0.4 percent for calendar year 2006.

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

CHAPTER 2

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

MedPAC makes payment update recommendations annually for fee-for-service Medicare. We use a framework to help us develop our recommendations in a thoughtful and consistent manner. The framework divides the process into two parts: first assessing the adequacy of Medicare payments for efficient providers in the current year (2005) and then assessing whether and how payments should change in the policy year (2006). When considering whether current payments are adequate, we account for policy changes other than the updates that are scheduled to take effect in the policy year under current law. This year we will be making update recommendations in six sectors: hospital inpatient, hospital outpatient, physician, skilled nursing facility, home health, and outpatient dialysis.

The goal of Medicare payment policy is to 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 outside the control of providers among types of services and patients and for varying market conditions, and then annually considering the need for a payment update. In this report, MedPAC makes payment update recommendations for six payment systems in the fee-for-service Medicare program.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that we consider the efficient provision of services in making update recommendations.

Our general approach to developing payment policy recommendations attempts to:

- make enough funding available in aggregate to cover the costs of efficient providers, thus maintaining Medicare beneficiaries' access to high-quality care, and
- distribute payments equitably among services and providers.

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

- Are payments at least adequate for efficient providers in 2005?
- How should Medicare payments change in 2006?

In the first part of our adequacy assessment, we judge whether Medicare payments compared with efficient providers' costs are too high or too low in the current year—2005 (Figure 2-1). In the second part, we assess how we expect efficient providers' costs to change in the next payment year—currently 2006. We may also consider changes in payment policy that would affect distribution of dollars. We then produce our recommended update and any other recommended policy changes.

This section of the chapter reviews our process. 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, and outpatient dialysis services.

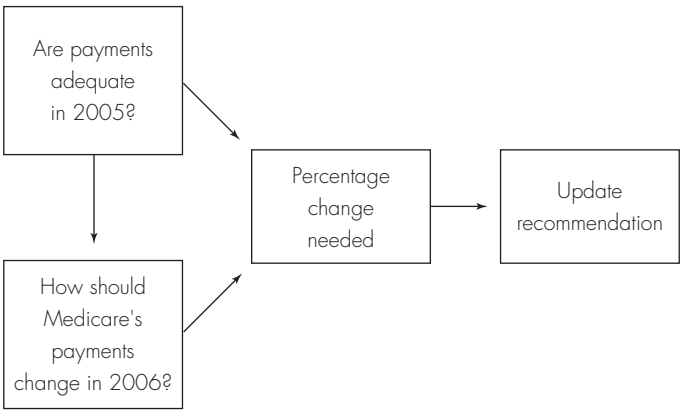
Are Medicare payments adequate in 2005?

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

- beneficiaries' access to care
- changes in the capacity of providers
- changes in the volume of services
- changes in the quality of care
- providers' access to capital
- Medicare payments and providers' costs for 2005

Because the goal of Medicare payment policy is to maintain beneficiaries' access to high-quality services by aligning payments with efficient providers' costs of furnishing health care, our measures are both beneficiary focused (for example, access to care) and provider focused (for example, the current year relationship of payments

FIGURE 2-1 **Framework for assessing payment adequacy and updating payment rates**



and costs). 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 rate could be 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. For example, providers may discriminate against beneficiaries if Medicare rates are too low and Medicare's share is not significant. 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 using several surveys. For home health services, we examine whether communities are served by providers using information CMS publishes on its website and, from a national survey, whether beneficiaries report they can obtain care.

Changes in the capacity 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 suggest that payments are more than adequate and unnecessary services are being provided. For instance, rapid growth in the number of home health agencies could suggest that Medicare's payment rates are at least adequate and potentially more than adequate. Facilities closing is the 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 policies and demand for services.

Changes in the volume of services

Increases in the volume of services beyond that expected for the increase in the number of beneficiaries 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 continue operating or to provide the same level of services. Either trend also could be explained by other factors, such as incentives of the payment system, population changes, changes in disease prevalence among beneficiaries, technology, practice patterns, and beneficiaries' preferences.

Changes in the quality of care

Assessing the relationship between quality and Medicare payments may be difficult. Quality is influenced by many factors, such as beneficiaries' preferences and compliance and providers' adherence to clinical guidelines. Generally Medicare's payment systems are largely neutral or negative toward quality—differences in quality of services provided do not result in differences in payments. Also, the influence of Medicare's payments on quality of care may be limited when Medicare is not the dominant payer. Even in this case, however, the program's quality improvement activities can influence the quality of care for a sector. Finally, generally increasing payments may not be an appropriate response to quality problems in a sector, particularly if other factors point to adequate payments. Rather, MedPAC supports linking payment to quality to hold providers accountable for the care they furnish (Chapter 4).

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—66 percent in hospitals and 88 percent in SNFs—come from private sources (such as 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 under particular government scrutiny because of fraudulent billings to the Medicare program.

We examine access to capital for both nonprofit and for-profit providers. Changes in bond ratings may indicate that access to needed capital for nonprofit entities 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, spending on construction, and overall volume of borrowing. For publicly owned providers, we can also monitor changes in share prices, debt, and other publicly reported financial information.

Payments and costs for 2005

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 2005 to inform our update recommendations for 2006.

For providers that submit cost reports to CMS—hospitals, skilled nursing facilities, home health agencies, and outpatient dialysis facilities—we 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. Because the latest payment and cost report data available to us are from 2003, we must estimate the 2005 margin.

To estimate payments, we first apply the annual payment updates specified in law for 2004 and 2005 to our 2003 base numbers. We then model the effects of other policy changes that will affect the level of payments and those—other than payment updates—that are scheduled to go into effect in the policy year (2006). 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 2005 would be if 2006 payment rules had been in effect.

To estimate 2005 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 based upon our review of trends in key indicators, including historical cost growth, productivity, and the distribution of cost growth among providers.

Using margins

In most cases, we assess Medicare margins for the services furnished in a single sector and covered by a specific payment system (for example, skilled nursing facility or 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 allocation of overhead costs or cross subsidies 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.

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

We reached this conclusion in part based on evidence 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). 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, the tools available for accurately calculating a total margin are problematic because inconsistent reporting among providers in a sector can result in misstatement of financial performance (Kane and Magnus 2001, MedPAC 2004). Finally, increasing Medicare payments to offset low total margins might discourage other payers from paying adequately or 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 maintain beneficiaries' access to high-quality services by aligning payments with *efficient* providers' costs of furnishing health care.

Although we do not consider total margins in our deliberations, we recognize that payers other than Medicare affect providers and can complicate our ability to assess payment adequacy. For example, if Medicare is not the dominant payer, changes in the number of providers may be influenced by other payers' payment

policies. When providers derive most of their payments from other payers, access to capital may not be a useful indicator of the adequacy of Medicare's payment.

We calculate a sector's aggregate Medicare margin to inform our judgment 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 different types 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, or rural areas) and by their teaching status (major teaching, other teaching, or nonteaching). In 2003, for example, MedPAC found that on average rural hospitals had significantly worse financial performance under Medicare than their urban counterparts (MedPAC 2003b). This finding 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 efficiency of providers, unbundling of the services included in the payment unit, and other changes in the product (such as reduced lengths of stay for 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 assessing the adequacy of payments relative to costs—the margin. No single standard governs this relationship. It varies from sector to sector and depends on the degree of financial risk faced by individual providers, which can vary over time.

Appropriateness of current costs

Our assessment of providers' costs and the relationship between Medicare's payments and providers' costs is influenced by whether current costs approximate what efficient providers would be expected to spend in furnishing high-quality care to beneficiaries. Measuring appropriateness of costs is particularly difficult in new payment systems. However, when we see providers respond dramatically to the incentives incorporated in a payment system, we may conclude that the initial costs were too high and that, therefore, the initial rates were set too high.

To assess whether reported costs provide a reasonable representation of the costs of efficient providers, we examine recent trends in the average cost per unit of output, variation in cost growth, and evidence of change in the product being furnished. Other things being equal, including the product being delivered, we would generally expect average growth in unit costs to be somewhat below the forecasted increase in inputs because of productivity improvements. The federal government should benefit from providers' productivity gains, just as private purchasers of goods in competitive markets benefit from the productivity gains of their suppliers.

Other payers also may affect providers' need to be efficient in delivering services. In a sector with a mix of payers or where Medicare is not dominant, if other payers do not promote discipline, providers may have higher cost growth than they would have if Medicare were dominant. For example, economic literature on the hospital industry suggests that providers that are under fiscal pressure generally have managed to slow their cost growth more than those facing less fiscal pressure (Gaskin and Hadley 1997).

Variation in cost growth among providers in a sector can give us insight into the range of performance that facilities are capable of achieving. For example, if some providers have more rapid cost growth than others, we might question whether those increases were appropriate. Changes in product can significantly affect unit costs. For example, substantial reductions in the number of visits in home health episodes would be expected to reduce the growth in provider costs. However, if costs per episode increased at the same time as the number of visits decreased, one would question the appropriateness of the cost growth.

Accurate reporting is important for determining costs. Current costs could be overstated and our margin calculations biased downward when data are obtained from unaudited cost reports. In some instances, some portion of costs have been found to be unallowable after CMS contractors audited facilities' cost reports.[3]

In principle we would like audits of all sectors' cost reports to ensure the accuracy of the reporting. For most providers, the current audit process reveals little about the accuracy of the Medicare cost information. The frequency of audits varies by sector, and when audits are done, they generally focus on a narrow set of components instead of broadly examining the accuracy of costs included in the

reports. A limited number of full-scale random audits could provide some insight into the quality of all cost report data submitted.

How should Medicare payments change in 2006?

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 quality and mix of inputs they use to furnish care remained 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. A provision of the MMA provides new monies for new technologies for hospital inpatient care, and a positive allowance in the 2006 update recommendation is no longer necessary.
- *Improvements in productivity*—Medicare's payment systems should encourage providers 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, MedPAC has 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 factor is a 10-year average of the U.S. Bureau of Labor Statistics' estimate of economy-wide, multifactor productivity growth, which is currently estimated at 0.8 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. Unless evidence suggests that this goal is unattainable systematically across a sector, Medicare should expect improvements in productivity consistent with the average realized by the firms and workers who fund it.

Update and distributional recommendations

MedPAC's approach to updating payments results 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 MMA requires MedPAC to consider the budget consequences of our recommendations. 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 impact of our recommendations on beneficiaries and providers. ■

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. Whether this phenomenon exists in other settings depends on how discretionary the services are.

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

3. For analysis and use of audited cost report data for outpatient dialysis services, see Section 2E.

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