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 acute inpatient and outpatient prospective payment systems in 2008 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.

COMMISSIONER VOTES: YES 14 • NO 0 • NOT VOTING 0 • ABSENT 3

2A-2 Concurrent with implementation of severity adjustment to Medicare's diagnosis related group payments, the Congress should reduce the indirect medical education adjustment in fiscal year 2008 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained from reducing the indirect medical education adjustment should be used to fund a quality incentive payment system.

COMMISSIONER VOTES: YES 13 • NO 1 • NOT VOTING 0 • ABSENT 3

2A-3 The Secretary should improve the form and accompanying instructions for collecting data on uncompensated care in the Medicare cost report and require hospitals to report using the revised form as soon as possible.

COMMISSIONER VOTES: YES 14 • NO 0 • NOT VOTING 0 • ABSENT 3

Section 2B: Physician services

2B The Congress should update payments for physician services in 2008 by the projected change in input prices less the Commission's expectation for productivity growth.

COMMISSIONER VOTES: YES 14 • NO 0 • NOT VOTING 0 • ABSENT 3

Section 2C: Outpatient dialysis services

2C The Congress should update the composite rate in calendar year 2008 by the projected rate of increase in the end-stage renal disease market basket index less the Commission's expectation for productivity growth.

COMMISSIONER VOTES: YES 14 • NO 0 • NOT VOTING 0 • ABSENT 3

CHAPTER 2

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

Chapter summary

The Commission makes payment update recommendations annually for fee-for-service Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system is changed. To determine an update, we first assess the adequacy of Medicare payments for efficient providers in the current year (2007). Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2008). Finally, we make a judgment as to what, if any, update is needed. When considering whether payments in the current year are adequate, we account for policy changes (other than the update) that are scheduled to take effect in the policy year under current law. This year we make update recommendations in eight sectors: hospital inpatient, hospital outpatient, physician, skilled nursing facilities, home health, outpatient dialysis, inpatient rehabilitation facilities, and long-term care hospitals. The analyses of payment adequacy by sector are in the sections that follow and in Chapter 3. ■

In this chapter

The goal of Medicare payment policy is to get good value for the program's expenditures. This means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources and preserving equity among providers and beneficiaries. Necessary steps toward achieving this goal involve:

- setting the base payment rate (i.e., the payment for services of average complexity) at the right level;
- developing payment adjustments that accurately reflect cost differences for varying market conditions outside the control of providers and among types of services and patients; and
- considering the need for a payment update and other policy changes annually.

Our general approach to developing payment policy recommendations attempts to do two things: first, make enough funding available in aggregate to cover the costs of efficient providers, and second, distribute payments equitably among services and providers. Together, these steps should maintain Medicare beneficiaries' access to high-quality care while getting the best value for taxpayers' and beneficiaries' resources.

To help determine the appropriate level of aggregate funding for a given payment system, we consider:

- Are payments at least adequate for efficient providers in 2007?
- How will efficient providers' costs change in 2008?
- How should Medicare payments change in 2008?

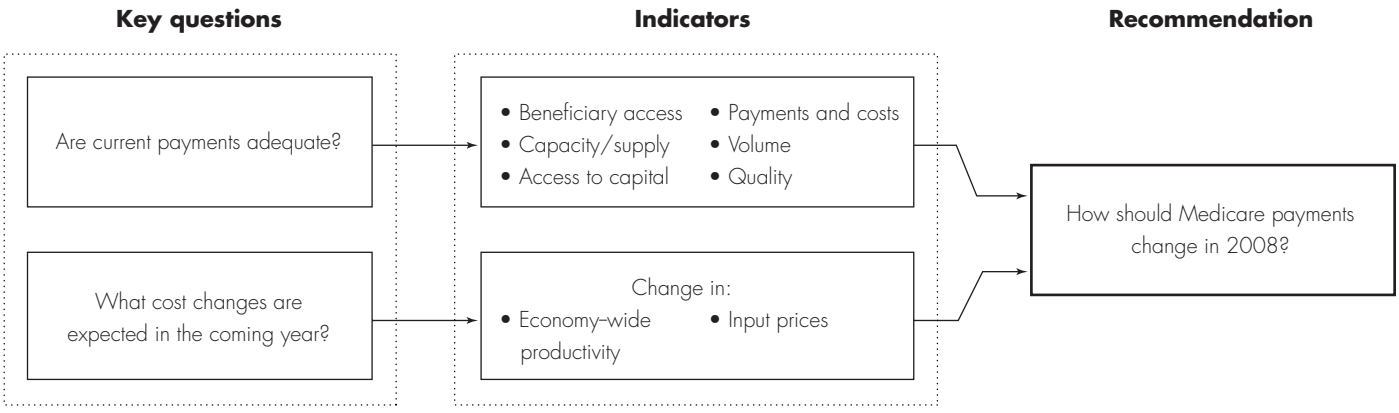
Efficient providers use fewer inputs to produce quality outputs. In the first part of our adequacy assessment, we judge whether Medicare payments are too high or too low compared with efficient providers' costs in the current year—2007. In the second part, we assess how we expect efficient providers' costs to change in the policy year—2008. Within a level of aggregate funding, we may also consider changes in payment policy that would affect the distribution of payments and improve equity among providers or improve equity and access to care for beneficiaries. We then recommend updates and other policy changes for 2008. This analytic process is illustrated in Figure 2-1.

Are Medicare payments adequate in 2007?

The first part of the Commission's approach to developing payment updates is to assess the adequacy of current Medicare payments. For each sector, we make a judgment by examining information on:

- beneficiaries' access to care
- changes in the capacity and 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 2007

FIGURE 2–1 **Payment adequacy framework**



Some measures focus on beneficiaries (e.g., access to care) and some on providers (e.g., the relationship between payments and costs in 2007). 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 the Commission to judge payment adequacy.

Beneficiaries' access to care

Access to care is an important indicator of the willingness of providers to serve Medicare beneficiaries and the adequacy of Medicare payments. (Poor access could indicate payments are too low; good access could indicate payments are adequate or more than adequate.) However, other factors unrelated to Medicare's payment policies may also affect access to care. These factors include coverage policy, beneficiaries' preferences, supplemental insurance, transportation difficulties, and the extent to which Medicare is the dominant payer for the service.

The measures we use to assess beneficiaries' access to care depend on the availability and relevance of information in each sector. For example, using results from several surveys, we assess physicians' willingness to serve beneficiaries and beneficiaries' opinions about their access to physician care. For home health services, using information on the CMS website, we examine whether communities are served by providers.

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 their costs. Changes in technology and practice patterns may also affect providers' capacity. For example, less invasive procedures or lower priced equipment could increase the capacity to provide certain services.

Substantial increases in the number of providers may suggest that payments are more than adequate and could raise concerns about the value of the services being furnished. 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. If Medicare is not the dominant payer, changes in the number of providers may be influenced more by other payers and their demand for services and thus may be difficult to relate to Medicare payments. When facilities close, we try to distinguish between closures that have serious implications for access to care in a community and those that may have resulted from excess capacity.

Changes in the volume of services

An increase 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. Reductions in the volume of services, on the other hand, may indicate that revenues are inadequate for providers to continue operating or to provide the same level of services. Changes in the volume of services are often difficult to interpret because increases or decreases also could be explained by other factors, such as incentives in the payment system, population changes, changes in disease prevalence among beneficiaries, technology, practice patterns, and beneficiaries' preferences. Explicit decisions about service coverage can also influence volume. For example, in 2004 CMS redefined arthritis conditions it thought appropriate for treatment in inpatient rehabilitation facilities (IRFs), a decision that contributed to a reduction in IRF volume. Changes in the volume of physician services must be interpreted particularly cautiously because some evidence suggests that volume may also go 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 and on the ability of providers to influence beneficiary demand for the services.

Changes in the quality of care

The relationship between changes in quality and Medicare payment adequacy is not direct. Many factors influence quality, including beneficiaries' preferences and compliance with providers' guidance and providers' adherence to clinical guidelines. Medicare's payment systems are not generally connected to quality; payment is usually the same, regardless of the quality of care. In fact, undesirable outcomes (e.g., unnecessary complications) may result in additional payments. The influence of Medicare's payments on quality of care may also be limited when Medicare is not the dominant payer. However, the program's quality improvement activities can influence the quality of care for a sector. Changes in quality are thus a limited indicator of Medicare payment adequacy. In addition, increasing payments through an update for all providers in a sector regardless of their individual quality may not be an appropriate response to quality problems in a sector, particularly if other factors point to adequate payments.

The Commission supports linking payment to quality to hold providers accountable for the care they furnish as discussed in our March 2004 and 2005 reports (MedPAC 2005, MedPAC 2004). Specifically, the Commission recommended that pay-for-performance programs be implemented for all the settings in this chapter: hospitals, physicians, and dialysis facilities and physicians furnishing services to dialysis patients. For hospitals and dialysis providers, measures are already available for such a program. For physicians, we described a two-step process that starts with measures of information technology function and then moves on to process of care and other measures. The Commission also recommended that pay for performance be adopted for home health agencies and Medicare Advantage plans.

The Commission developed four principles for Medicare's pay-for-performance programs.

- The program should reward providers based on improving care and achieving absolute better performance to have the broadest effect on providers' incentives and thus beneficiaries' care.
- The program should be funded by setting aside, initially, a small proportion of payments (e.g., 1 percent to 2 percent of payments) to minimize possible disruption to beneficiaries and providers.
- The program should be budget neutral. It should distribute all withheld dollars every year; pay for performance is a way to improve quality of care, not to realize savings.
- The program should have a process to update the measures to reflect changes in quality measurement and practice patterns. We provide a detailed description of the type of entity we envision for this task in our March 2005 report.

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 (or, in some cases, even on the expectation of changes in the adequacy of Medicare payments). However, access to capital may not be a useful indicator of the adequacy of Medicare payments when the sector has little need for capital, when there is a perception that regulatory action may affect the sector, or when providers derive most of their payments from other payers or other lines of business. For example, most hospital and skilled nursing facility (SNF) revenues come from private sources (e.g., health insurance) or other government payers (e.g., Medicaid).

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 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 2007

For most payment sectors, we estimate aggregate Medicare payments and costs for the year preceding the policy year. In this report, we estimate payments and costs for 2007 to inform our update recommendations for 2008.

For providers that submit cost reports to CMS—acute care hospitals, SNFs, home health agencies, outpatient dialysis facilities, IRFs, and long-term care hospitals—we estimate total Medicare-allowable costs and assess the relationship between Medicare's payments and those costs. We typically express the relationship between payments and costs as a payment margin, which is calculated as payments less costs divided by payments.

To estimate payments, we first apply the annual payment updates specified in law for 2006 and 2007 to our 2005 base data. We then model the effects of other policy changes that will affect the level of payments including those—other than payment updates—that are scheduled to go into effect in 2008. This method 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 2007 would be if 2008 payment rules were in effect. To estimate 2007 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 the product (i.e., changes within the service provided, such as fewer visits in an episode of home health care) and trends in key indicators, such as 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 (e.g., SNF or home health services). When a facility provides services that are paid for in multiple payment systems, however, our measures of payments and costs for an individual sector may become distorted because of allocation of overhead costs or cross subsidies among services. In these instances, we assess—to the extent possible—the adequacy of payments for the whole range of Medicare services the facility furnishes. For example, a hospital might furnish inpatient, outpatient, SNF, home health, psychiatric, and rehabilitation services (each of which is paid under a different Medicare payment system). We compute an overall hospital margin encompassing Medicare-allowed costs and payments for all the sectors.

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

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 subgroups of providers that are important in Medicare's payment policies. For example, because location and teaching status enter into the payment formula, we calculate Medicare margins based on where hospitals are located (in urban or rural areas) and by their teaching status (major teaching, other teaching, or nonteaching).

Multiple factors can contribute to the difference 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 (e.g., reduced lengths of stay at inpatient hospitals). Information about the extent to which these factors have contributed to the difference may help in deciding how much to change payments.

Finally, the Commission makes a judgment when assessing the adequacy of payments relative to costs. 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 change over time.

Appropriateness of current costs

Our assessment of the relationship between Medicare's payments and providers' costs is influenced by whether costs reflect efficient providers' expected spending on high-quality care. Measuring appropriateness of costs is particularly difficult in new payment systems because changes in response to the incentives in the new system are to be expected. For example, the number and kinds of visits in a home health episode changed significantly after the introduction of the home health prospective payment system. In other systems, coding may change. Any kind of rapid change can make it difficult to measure costs per unit of comparable product.

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 generally expect average growth in unit costs to be somewhat below the forecasted increase in input prices 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 and market conditions also may affect providers' efficiency. In a sector where Medicare is not dominant, if other payers do not promote cost containment, providers may have higher growth in cost than they would have if Medicare were dominant. Lack of cost pressure would be more common in markets where a few providers dominate and have negotiating leverage over the payers. For example, economic literature on the hospital industry and our analysis suggest that providers that are under cost pressure generally have managed to slow their growth in cost more than those facing less cost pressure (Gaskin and Hadley 1997, MedPAC 2005).

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 growth in cost than others, we might question whether those increases were appropriate.

Changes in product can significantly affect unit costs. Returning to the example of home health, substantial reductions in the number of visits in home health episodes would be expected to reduce the growth in per episode costs. If costs per episode instead 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. When data are obtained from unaudited cost reports, costs could be understated or overstated. In some instances, some portion of costs has been found to be unallowable after CMS contractors audited facilities' cost reports.

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. When audits are done, they generally focus on a narrow set of cost components that directly affect payment instead of broadly examining the accuracy of costs included in the reports.

What cost changes are expected in 2008?

The second part of the Commission's approach to developing payment update recommendations is to account for anticipated 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 of input price changes—the Medicare Economic Index (before it is adjusted for productivity). Forecasts of these indexes 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. Any errors in the forecast are taken into account in future years while judging payment adequacy.

Another factor that may also affect providers' costs in the coming year is improvement 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, the Commission has adopted a policy goal to create incentives for efficiency, including an adjustment for productivity when accounting for providers' cost changes in the coming year. The Commission's productivity factor—1.3 percent for our 2008 deliberations—is a 10-year average of the Bureau of Labor Statistics' (BLS) estimate of economy-wide, multifactor productivity growth. 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 for reasons outside the industry's control, Medicare should expect improvements in productivity consistent with the average realized by the firms and workers who fund the Medicare program.

Due to a change in data availability, the productivity factor for our 2008 deliberations is substantially higher than it was for 2007. The BLS now releases its multifactor productivity data a year earlier than it did previously. Accordingly, our calculation of the most recent 10 years adds two new years of data (2003 and 2004) and drops two years (1993 and 1994). Because the two dropped years had relatively low productivity (0.3 percent in 1993 and 0.8 percent in 1994) and the two new years had high productivity (2.7 percent in 2003 and 2.9 percent in 2004), the 10-year average has increased markedly. BLS officials attribute recent gains in productivity to improved use of information technology, firm specialization resulting in outsourcing of certain business functions, and contributions from research and development.

How should Medicare payments change in 2008?

The Commission's judgments about payment adequacy and expected cost changes result in an update recommendation for each payment system. Coupled with the update recommendations, we may also make recommendations about the distribution of payments among providers. These distributional changes are sometimes, but not always, budget neutral. Our recommendations for pay for performance are one example of distributional changes that will affect providers differentially based on their performance.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Commission 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 impacts of our recommendations on beneficiaries and providers. ■

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