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 2009 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.

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

2A-2 The Congress should reduce the indirect medical education adjustment in 2009 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the indirect medical education adjustment should be used to fund a quality incentive payment program.

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

Section 2B: Physician services

2B The Congress should update payments for physician services in 2009 by the projected change in input prices less the Commission's adjustment for productivity growth. The Congress should enact legislation requiring CMS to establish a process for measuring and reporting physician resource use on a confidential basis for a period of two years.

COMMISSIONER VOTES: YES 13 • NO 2 • NOT VOTING 1 • ABSENT 1

Section 2C: Outpatient dialysis services

2C The Congress should update the composite rate in calendar year 2009 by the projected rate of increase in the end-stage renal disease market basket index less the Commission's adjustment for productivity growth. The Commission reiterates its recommendation that the Congress implement a quality incentive program for physicians and facilities that treat dialysis patients.

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

Section 2D: Skilled nursing facility services

2D-1 The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2009.

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

RECOMMENDATIONS

2D-2 The Congress should establish a quality incentive payment policy for skilled nursing facilities in Medicare.

COMMISSIONER VOTES: YES 10 • NO 3 • NOT VOTING 2 • ABSENT 2

2D-3 To improve quality measurement for skilled nursing facilities, the Secretary should:

- add the risk-adjusted rates of potentially avoidable rehospitalizations and community discharge to its publicly reported post-acute care quality measures;
- revise the pain, pressure ulcer, and delirium measures currently reported on CMS's Nursing Home Compare website; and
- require skilled nursing facilities to conduct patient assessments at admission and discharge.

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

Section 2E: Home health services

2E The Congress should eliminate the update to payment rates for home health care services for calendar year 2009.

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

Section 2F: Inpatient rehabilitation facility services

2F The update to the payment rates for inpatient rehabilitation facility services should be eliminated for fiscal year 2009.

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

Section 2G: Long-term care hospital services

2G The Secretary should update payment rates for long-term care hospitals for rate year 2009 by the projected rate of increase in the rehabilitation, psychiatric, and long-term care hospital market basket index less the Commission's adjustment for productivity growth.

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

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 (2008). Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2009). 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, outpatient dialysis, skilled nursing facility, home health, inpatient rehabilitation facilities, and long-term care hospitals. The analyses of payment adequacy by sector are in the sections that follow. ■

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. 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 market, service, and patient cost differences beyond providers' ability to control; and
- considering the need for annual payment updates and other policy changes.

Our general approach to developing payment policy recommendations attempts to do two things: first, make enough funding available to ensure that payments are adequate to cover the costs of efficient providers, and second, improve payment accuracy 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 2008?
- How will efficient providers' costs change in 2009?

Taking into account those two factors, we then determine how Medicare payments should change in 2009.

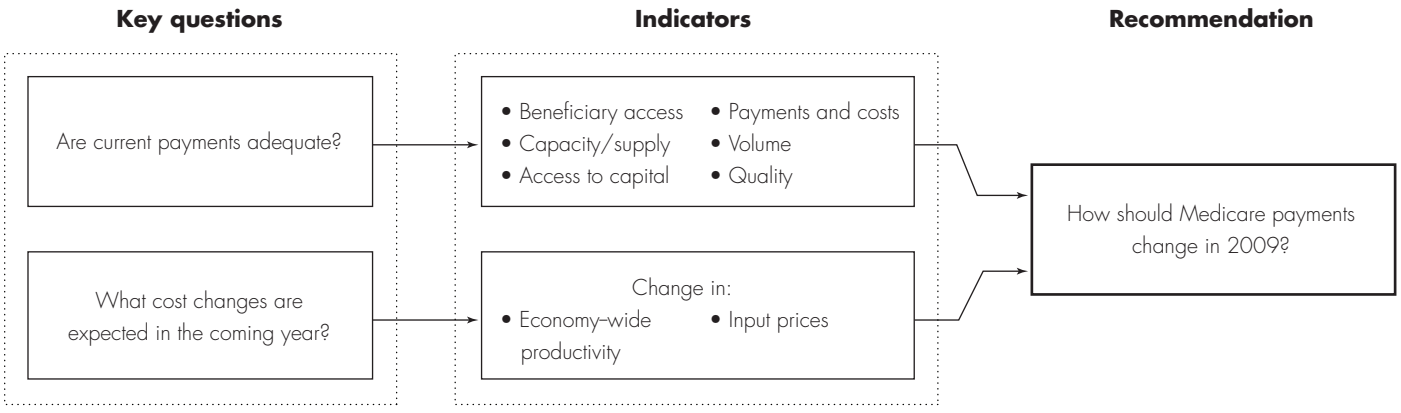
Efficient providers use fewer inputs to produce quality outputs. In the first part of our adequacy assessment, we judge whether Medicare payments are too high or too low compared with efficient providers' costs in the current year—2008. In the second part, we assess how we expect efficient providers' costs to change in the policy year—2009. Within a given level of 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 2009. This analytic process is illustrated in Figure 2-1.

Are Medicare payments adequate in 2008?

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 2008

FIGURE 2–1 **Payment adequacy framework**



Some measures focus on beneficiaries (i.e., access to care) and some focus on providers (i.e., the relationship between payments and costs in 2008). We consider multiple measures because the direct relevance, availability, and quality of each type of information vary 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 (HHAs) could suggest that Medicare's payment rates are at least adequate and potentially more than adequate. If Medicare is not the dominant payer for a given provider type, 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. However, changes in the volume of services are often difficult to interpret because increases and decreases 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 2005 and 2004 reports (MedPAC 2005b, 2004). Specifically, the Commission recommended that pay-for-performance programs be implemented for hospitals, physicians, dialysis facilities and physicians furnishing services to dialysis patients, HHAs, and Medicare Advantage plans. 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 moves on to process of care and other measures. In this report, the Commission also recommends that pay for performance be adopted for skilled nursing facilities (SNFs).

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 (MedPAC 2005b).

Providers' access to capital

Access to capital is necessary for providers to maintain and modernize their facilities and capabilities for patient care. Widespread inability to access capital 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 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 monitor changes in share prices, debt, and other publicly reported financial information.

Payments and costs for 2008

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 2008 to inform our update recommendations for 2009.

For providers that submit cost reports to CMS—acute care hospitals, SNFs, HHAs, outpatient dialysis facilities, IRFs, and long-term care hospitals (LTCHs)—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 2007 and 2008 to our 2006 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 2009. 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 2008 would be if 2009 payment rules were in effect. To estimate 2008 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 (i.e., 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 some combination of 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 certain subgroups of providers with unique roles in the health care system. 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 individual providers face, 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 provider efficiency. 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 home health prospective payment system (PPS) was introduced. In other systems, coding may change. For example, the hospital inpatient PPS is phasing in a patient classification system that will result in more accurate payments but is also predicted to result in higher payments because of improved provider coding. Any kind of rapid change can make it difficult to measure costs per unit of a comparable product.

To assess whether reported costs reflect the costs of efficient providers, we examine recent trends in the average cost per unit of output, variation in standardized costs and cost growth, and evidence of change in the product being furnished. 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 payers. Providers that are under cost pressure generally have managed to slow their growth in cost more than those facing less cost pressure (MedPAC 2005b, 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 growth in cost than others, we might question whether those increases are appropriate.

Changes in the 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. We would like audits of cost reports to ensure the accuracy of the reporting. At the same time, we need to use what information is available to us to measure financial performance.

What cost changes are expected in 2009?

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. A 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 affect providers' costs in the coming year is improvement in productivity. Competitive markets demand continual improvements in productivity from workers and firms. These workers and firms pay the taxes used to finance Medicare. Medicare's payment systems should encourage providers to produce a unit of service as efficiently as possible while maintaining quality. Consequently, the Commission may choose to apply an adjustment to the update to encourage this efficiency. The Commission begins its deliberations with the assumption that all providers can achieve efficiency gains similar to the economy at large (the 10-year average of productivity gains in the general economy, currently 1.5 percent). But the Commission may alter that assumption depending on the circumstances of a given set of providers in a given year. This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare.

Limitations to payment adequacy analysis across post-acute care settings

Medicare provides coverage for beneficiaries in four post-acute care (PAC) settings: SNFs, HHAs, IRFs, and LTCHs. Prospective payment systems for each setting were developed and implemented separately to control growth in spending and encourage more efficient provision of services in each setting.

While we assess the adequacy of payments under each of these PPSs, these separate systems encompass their own incentives (both positive and negative) that may distort the provision of PAC. The Commission previously stated that the individual "silos" of PAC do not function as an integrated system; there is no common patient instrument used to assess patient care needs and guide placement decisions, payments reflect each setting rather than the resource needs of the patients, and outcomes do not gauge the value of the care furnished. Several barriers inhibit the integration of the current systems and undermine the program's ability to purchase high-quality care in the least costly PAC setting consistent with the care needs of the beneficiary. These barriers include:

- inaccurate case-mix measurement,
- incomparable data on the quality and outcomes of care, and
- lack of evidence-based standards.

Inaccurate case-mix measurement

In three of the four PAC settings, case-mix measures do not accurately reflect the resources used to treat certain types of patients; as a result, the measures do not track differences in the costs of care. For example, the SNF PPS includes strong incentives for facilities to furnish therapy but does not adjust payments for differences in the need for nontherapy ancillary services (e.g., drugs). As a

result, the case-mix system encourages providers to admit rehabilitation patients and discourages them from treating beneficiaries who need a high level of medical care. In another example, a recent study of the LTCH PPS found that variations in profitability by case-mix group result from a systematic understatement of the costs for cases that use relatively more ancillary services (RTI 2006). Refining the case-mix weights could correct this bias.

Incomparable quality and outcome data

An overarching limitation in moving toward a more integrated PAC system is the lack of comparable information across settings. The PAC settings do not use a common patient assessment tool to gather information about the functional status, diagnoses, comorbidities, and cognitive status of patients. Medicare requires three of the four settings to use a patient assessment tool, but each setting uses a different one. As a result, the program cannot compare costs, quality of care, and patient outcomes while controlling for differences in the mix of patients treated. In short, the program cannot measure the value it gets from PAC purchases.

Even within a setting, the case-mix, quality, and outcome data that are gathered make it difficult, if not impossible, to make comparisons among provider types. For example, our ability to assess the quality of care that SNFs provide to beneficiaries is limited because few quality measures focus specifically on the care provided during a short-term post-acute stay. Although the Commission uses two risk-adjusted measures to evaluate SNF care—the rate of preventable rehospitalizations and the rate of discharges to the community—CMS does not track either measure. And because SNFs do not assess patients at admission or discharge, patient progress during a stay—such as changes in functional status—cannot be directly evaluated (Chapter 2D).

The Deficit Reduction Act of 2005 (DRA) requires CMS to conduct a demonstration that supports PAC payment reform across settings. CMS has taken steps to respond to the mandate. Its contractor, RTI, developed a PAC assessment instrument and piloted it in the Chicago area in hospitals, LTCHs, IRFs, HHAs, and SNFs. A cost and resource use data collection tool was also developed and tested in various settings in the Boston area. Data collection will begin in the first market in March 2008 and in nine additional markets beginning in April 2008. A report on that demonstration is due to the Congress in 2011. Thus, while CMS envisions an integrated system and has taken a key step toward developing one, implementation is years away.

Lack of evidence-based standards

The lack of evidence-based standards of care (to identify which patients need how much care) results in large variations in practice and costs, with no way to discern the appropriate level of care. Beneficiaries may not receive medically necessary, high-quality care in the least costly PAC setting consistent with their clinical conditions. Although the program has some patient and facility criteria to match patient care needs to the treatment setting, there is some overlap in the types of patients treated across settings. For example, patients who need wound care or who require rehabilitation after hip surgery are treated in various PAC settings, with very different cost implications for the program.

The lack of evidence-based standards also means that, even within a setting, we do not know which treatments are necessary for which types of patients. Guidelines do not exist for many conditions to delineate how much care is typically needed, when more care is likely to result in better outcomes, and when patients are unlikely to improve with additional treatment.

Implications for financial performance

The barriers that undermine the integration of care across PAC settings—inaccurate case-mix measurement, incomparable quality and outcome information, and lack of evidence-based standards of care—also limit our ability to assess differences in financial performance across providers in the same setting. Without an adequate case-mix adjuster, observed differences in costs could reflect differences in the mix of patients treated rather than efficiency. Differences in costs could also be attributable to variations in the quality of care furnished and the outcomes patients achieve.

Within each PAC setting, provider performance varies considerably and some providers consistently perform better than others. In examining differences in Medicare margins, the Commission reported that size, case mix, location, and ownership explained very little of the variation across HHAs (MedPAC 2005a). Across all four PAC settings, Medicare margins varied by ownership, raising questions about how good performance can be achieved. In recent years, PAC providers with consistently better financial performance generally had lower resource use, lower unit costs, and slower growth in cost. Before concluding that low-cost providers are efficient, we need to know if they compromised the quality of care they furnished or if they selected certain types of patients.

To become a value-based purchaser, Medicare needs to know whether paying more for care buys better patient outcomes.

Broad PAC reform that the Commission favors—and that the post-acute demonstration mandated by the DRA envisions—has begun but is several years away until results are available. In the meantime, services furnished in PAC settings will likely continue to be paid for under the respective PPSs. Within each setting, then, the program must continue to ensure that payments are adequate, while discouraging patient selection and encouraging providers to furnish high-quality services.

How should Medicare payments change in 2009?

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.

Further examination of payment adequacy

As discussed in Chapter 1, it is essential to look at payment adequacy not only within the context of individual payment systems but also in terms of Medicare as a whole. The Commission is alarmed by the trend in Medicare spending—a growth rate well above that of the economy overall—without a commensurate increase in value to the program, such as higher quality of care or improved health status. If unchecked, the growth in spending, combined with retirement of the baby boomers and Medicare's prescription drug benefit, will result in the Medicare program absorbing unprecedented shares of the gross domestic product and of federal spending. Slowing the increase in Medicare outlays is important; indeed, it is urgent. Medicare's rising costs, coupled with the projected growth in the number of beneficiaries, will significantly burden taxpayers.

The financial future of Medicare prompts us to look at payment policy in a different way and ask what can be done to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity.

In many past reports, the Commission has stated that Medicare should institute policies that improve the value of the program to beneficiaries and taxpayers. We believe these policies should help improve the Medicare payment system. Policies such as pay for performance that link payments to the quality of care providers furnish should be implemented. To reduce unwarranted variation in volume and expenditures, Medicare should collect and distribute information about how providers' practice styles and use of resources compare with those of their peers. Ultimately, this information could be used to adjust payments to providers. Increasing the value of the Medicare program to beneficiaries and taxpayers requires knowledge about the costs and health outcomes of services. Until more information on the comparative effectiveness of new and existing health care treatments and technologies is available, patients, providers, and the program will have difficulty determining what constitutes good-quality care and effective use of resources. These ideas for broad system reform have little, or no, current implementation in the Medicare program and face wide opposition from provider and interest groups. If these reforms are enacted and providers are still in opposition, it may be necessary to create payment adjustments to encourage movement toward—and wider use of—these policies.

As we examine each of the payment systems, we also look for opportunities to develop policies that would create incentives for providing high-quality care efficiently across providers and over time. Some of the current payment systems create strong incentives for increasing volume, and very few of these systems encourage providers to

work together toward common goals. Future Commission work will examine innovative policies for the fee-for-service program.

We will continue to focus on how to reward the efficient provider. That will require identifying who those providers are, how they are efficient, and how to change the current Medicare payment system to reward their better provision of service. Currently, Medicare pays all health care providers without differentiating on the basis of quality or resource use across providers and over time. In fact, Medicare often pays more when poor care results in complications that require additional treatment. Paying more for the efficient provider would reverse incentives in the Medicare payment system that often reward providers for lower quality care.

Until we can pay appropriately for the efficient provider, Medicare should exert continued financial pressure on providers to control their costs, much as would happen in a competitive marketplace. We have found, for example, that hospitals under financial pressure from the private sector tend to control their costs and cost growth better than those with non-Medicare revenues that greatly exceed costs (MedPAC 2007). The private sector is not the only potential source of financial pressure on hospitals; Medicare payment rates can also influence cost growth (Gaskin and Hadley 1997). In recent years, Medicare inpatient payments have increased at a rate higher than the hospital market basket, but payments have not risen to a level that fully accommodates the rapid increase in hospital costs. By not fully accommodating growth in hospital costs, Medicare can place some pressure on hospitals to constrain costs. Many stakeholders have expressed concerns about negative Medicare margins; however, negative Medicare margins have not affected providers' investment in new capital or other expansion projects. In a policy world that is constantly changing, even negative margin projections can reverse. In light of this information, it may be important for the Commission to take a more aggressive look at adequacy indicators for providers and set a more demanding standard in determining which providers qualify for a payment update each year. ■

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