

Report to the Congress:
Medicare payment policy

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Statement of
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Committee on Ways and Means
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Chairman Johnson, Congressman Stark, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss MedPAC's March report including our recommendations on Medicare payment policy.

The Congress has charged MedPAC with reviewing and making recommendations concerning Medicare payment policies. The Commission's recommendations aim to ensure that Medicare's payment systems set rates that cover the costs efficient providers would incur in furnishing care to beneficiaries. If payments are set too low, providers may not want to participate in the program and Medicare beneficiaries may not have access to quality care. If payments are set too high, taxpayers and beneficiaries bear too large a burden.

In our March report to the Congress, we recommend updates and policy improvements for seven Medicare prospective payment systems (PPSs). After examining indicators such as providers' financial performance under Medicare, changes in the volume of services, the quality of and access to care, providers' access to capital, and market entry or exit, we find that in general, Medicare payments are adequate to cover the costs of efficient providers. Therefore we recommend the following updates for 2004:

- hospital inpatient prospective payment system: a marketbasket index (representing input price changes), less 0.4 representing the net of an increase for technological change and a decrease for expected productivity gains;
- hospital outpatient, physician, and outpatient dialysis payment systems: marketbasket less an allowance of 0.9 percent for expected productivity gains; and
- skilled nursing, home health, and ambulatory surgical center payment systems: zero. For many skilled nursing and home health providers, current payments exceed costs by a large enough margin to offset expected cost growth in 2004. For ambulatory surgical centers the growth in service volume and number of providers suggests payment is more than adequate.

These update recommendations are coupled with others that improve the distribution of payments in a sector to better follow the costs of patient care, or that improve consistency in Medicare purchasing. The update and other recommendations for each sector should be considered as a package, because they are interrelated, and in some cases protect potentially vulnerable providers and thus access to care for beneficiaries.

We also discuss several broader issues related to Medicare payments:

- considering the context for Medicare payment recommendations (e.g. how the growth of Medicare expenditures compares to that of the economy, the federal budget, and the amount paid by other payers; how to characterize the spending impact of our recommendations);
- assessing Medicare beneficiaries' access to care;
- deciding how Medicare should pay for new technologies; and
- examining the health insurance choices available to Medicare beneficiaries and the characteristics of insurance markets that help determine those choices.

Context

We include in our report spending trends not just for Medicare but also for private sector payers and other federal health care programs. Over the long term, the rate of increase in per capita spending for Medicare beneficiaries has been similar to that for members of private sector health insurance plans and several government-sponsored plans (e.g., the federal employees health benefits program). Year to year, there are different patterns and fluctuations, but the factors driving health care costs appear to operate similarly for all payers. We also report trends in Medicare's share of health care spending in the United States and of the federal budget, and the share overall health care spending represents of gross domestic product. Over the next few decades Medicare will constitute a greater proportion of economic output. Similarly, it will create greater pressure within the federal budget and on beneficiary resources through increased cost sharing.

Therefore, we include in our report estimates of spending changes resulting from each of our recommendations—presented as ranges over one- and five-year periods—and the implications for beneficiaries and providers. Please note that these spending estimates cannot simply be added together to compute an overall estimate. Unlike official budget estimates, they do not take into account the complete package of policy recommendations, the interactions among them, or assumptions about changes in provider behavior.

Assessing payment adequacy and updating payments

We recommend payment adjustments for seven different Medicare prospective payment systems. For each system, we assess whether payments are adequate to cover the cost of efficient providers by using indicators such as

providers' financial performance under Medicare, changes in the volume of services, quality of and access to care, providers' access to capital, and market entry or exit. We then address the likely change in efficient providers' costs in 2004. We estimate input price inflation (as measured by a marketbasket index for each sector); allow, when needed, for technological changes that both improve quality and significantly increase costs; and determine a reasonable expectation for productivity gains. For expected productivity gains, we use the 10-year average change in multifactor productivity in the general economy. Our update recommendations reflect our assessment of all of these factors for each payment system. When appropriate, we also make recommendations to improve the distribution of payments among providers within each payment system.

Hospital inpatient and outpatient services In the hospital sector we make both update and distributional recommendations. These should be considered as a package both because they are so closely interrelated, and because some distributional recommendations would help certain hospitals that are particularly vulnerable, such as some rural hospitals.

Overall we find that Medicare payments for hospital services are adequate as of fiscal year 2003. Using a margin calculation encompassing nearly all Medicare payments to hospitals, and thus not influenced by cost allocation problems, we estimate a margin for hospital services in 2003 of 3.9 percent. (This includes changes legislated for fiscal year 2004 that will reduce payments.) Other broad indicators, such as trends in volume and access to capital, are also generally consistent with a conclusion of adequate payments. This conclusion, together with consideration of factors likely to affect costs in the coming year—including input price inflation, technological advances, and productivity—support an update for 2004 of marketbasket minus 0.4 percent for inpatient services. Because significant technological advances affecting outpatient services are accounted for through new technology provisions in that payment system, we recommend an outpatient update of market basket minus 0.9 percent for productivity improvement.

The distribution as well as the level of inpatient payments is an issue. For example, the overall Medicare margin varies by hospital group, with hospitals in large urban areas having a margin of 6.9 percent and rural hospitals having a negative margin of 1.9 percent. We recommend five policy changes to improve the distribution of inpatient payments:

- expand the current transfer policy for patients in certain diagnosis related groups (DRGs) who are discharged to post-acute settings after very short hospital stays;
- implement an adjustment for hospitals with very few patients;
- reevaluate the labor share used for geographic adjustment of rates;
- increase the cap on disproportionate share payments that applies to most rural hospitals and urban hospitals with less than 100 beds; and,
- eliminate the differential in base rates for hospitals in rural and small urban areas.

This last recommendation was recently put in law for the period from April 1, 2003 to the end of fiscal year 2003.

We recommend expanding the post-acute care transfer policy to additional DRGs to better allow payments to follow patient care and to prevent hospitals that cannot discharge patients to post-acute care from being disadvantaged. We have recommended the other four policy changes in previous reports and reiterate them now as part of the comprehensive package that, taken together with the inpatient update recommendation, will help maintain the financial viability of the hospital sector. The result of the total package of our hospital recommendations is a 3.2 percent inpatient payment increase for all hospitals taken together. All hospital groups we evaluated show an increase, although the magnitude differs. For example, rural hospitals and hospitals in smaller urban areas would receive increases greater than the market basket (4.2% and 3.6%, respectively). Hospitals in large urban areas, on the other hand, would receive an increase less than the market basket (2.7%). In short, the groups with lower margins before our recommendations would receive higher increases.

A final important issue is the current indirect medical education adjustment to inpatient payments. That adjustment of an additional 5.5 percent for each 10 percent increase in the resident-to-bed ratio, provides payments about twice the level justified by the empirical evidence of the relation between teaching activity and hospitals' Medicare costs. The Commission is not satisfied with the current policy because there is no accountability for the use of the payments above the empirical level. We will explore ways to better target those payments to advance specific Medicare policy objectives through increased accountability.

Physician services Medicare payment rates for physician services are based on a fee schedule and are updated annually based on the sustainable growth rate system that ties updates to growth in the national economy and other

factors. Under this system, the update for 2003 would have been negative 4.4 percent. CMS implementation of recent Congressional action, however, is now expected to produce a positive update of 1.6 percent for 2003.

When assessing payment adequacy we find a mixed picture. The number of physicians billing Medicare has increased and national indicators of access are still good. There are, however, anecdotal reports of access problems in some geographic markets and specialties. A national survey of physicians suggests they are becoming more selective about accepting new Medicare patients—but that is true for private HMO and Medicaid patients as well. Finally, Medicare payment rates have fallen somewhat relative to payment rates in the private sector, although they are still above levels seen in the mid-1990s.

Although there was a negative update in 2002, the volume of physician services increased; as a result, so did program spending. Program spending for physician services is projected to continue to increase even in the face of future negative updates. For example, the March 2002 Congressional Budget Office baseline projected average annual growth in program spending for physician services of 4 percent from 2001 to 2006 even with negative updates for five years.

From this assessment, and given recent Congressional action on the 2003 update, the Commission concludes that payments are adequate. Therefore, we recommend an update for 2004 that equals the estimated change in input prices for physician services, less an adjustment for productivity growth.

Skilled nursing facility services Aggregate Medicare payments for skilled nursing facilities (SNFs) are at least adequate for fiscal year 2003. For freestanding SNFs—about 90 percent of providers in this sector—we estimate aggregate Medicare margins to be 11 percent in 2003. Including the 10 percent of SNFs that are hospital-based, the aggregate SNF margin is about 5 percent. The high margin for freestanding SNFs reflects a decline in costs in recent years. This decline is a response to incentives in the SNF prospective payment system (PPS) following high cost growth prior to its introduction. Preliminary evidence indicates that the decline in costs has not resulted in a lower quality of care. Because the PPS for SNFs is still relatively new, we expect this cost trend to continue into 2004, offsetting increases in input prices and other factors. Therefore, we recommend that the Congress not update payment rates for SNFs for fiscal year 2004.

Weaknesses in the current classification system for care in SNFs result in payments that are not distributed appropriately to account for the expected resource needs of different types of Medicare beneficiaries. Resources should be reallocated until the classification system is improved or replaced. As a start, we recommend that the Congress give the Secretary authority to reallocate money currently used as a payment add-on for rehabilitation classification groups to other classification groups so that payment more closely follows patient costs. This reallocation will benefit hospital-based SNFs to the extent that they serve patients with conditions more complex than those of patients in freestanding SNFs; therefore, no separate update for hospital-based SNFs is recommended. If this reallocation does not occur in a timely manner, however, the Congress should provide a marketbasket update less productivity adjustment of 0.9 percent for hospital-based SNFs only.

Home health services Current aggregate Medicare payments for home health services are more than adequate relative to costs. For the first time, we now have cost data showing how home health agencies are performing under the PPS. We estimate that the Medicare margin for home health services in fiscal year 2003 will be over 23 percent, even after accounting for the so-called 15 percent payment reduction and the expiration of the current 10 percent rural add-on. Another measure of financial performance, the ratio of payments to charges, also indicates more than adequate payments. Payments are well above charges—12 percent overall—and assuming agencies charge more than costs, payments exceed costs by at least 12 percent. Providers have responded to the new PPS by changing the services they provide during home health episodes: providing fewer visits but more therapy. The cost of providing an episode of home health services is lower as a result. Other broad indicators also suggest that payments are adequate: access to care is generally good, the rate of decline in the number of users has decreased, and the entry and exit of agencies has remained stable for the third year in a row.

In the past, we have recommended updates that emphasized stability for this sector because we lacked data on agencies' financial performance, and also wanted to give providers time to adapt to the new payment system. Home health agencies have adapted, and we expect them to continue to adapt during the coming year, further reducing the costs of providing an episode of care. Therefore, we recommend that the Congress not update payment rates for home health services for fiscal year 2004. Because of potential challenges that providers may face in rural areas, we also recommend that the Congress extend for one year, at a rate of 5 percent, add-on payments for home health services provided to Medicare beneficiaries who live in rural areas.

Outpatient dialysis services Current aggregate Medicare payments for outpatient dialysis services for beneficiaries with end-stage renal disease are adequate. Together, payments for composite rate services and injectable drugs—the two main components of payment to providers of outpatient dialysis services—exceeded providers’ costs by about 4 percent in 2001. We conservatively estimate that the aggregate payment-to-cost ratio will be no lower than 1.01 in 2003. If payment for injectable drugs and their profitability relative to composite rate services continue to increase from 2001 to 2003, as is likely, the ratio will be higher. Other indicators—such as continued entry of for-profit freestanding providers, increases in the volume of services provided, lack of evidence of beneficiaries facing systematic problems in accessing care, continued improvements in the quality of dialysis care, and providers enjoying adequate access to capital—together support the conclusion that Medicare’s outpatient dialysis payments are adequate relative to efficient providers’ costs. To account for changes in providers’ costs in the coming year, the Congress should update the composite rate for outpatient dialysis services for 2004 by the change in input prices, less a 0.9 percent adjustment for productivity gains.

Ambulatory surgical center services An ambulatory surgical center (ASC) is a distinct entity that exclusively furnishes outpatient surgical services. The current payment rates for ASC services are based on a cost survey conducted in 1986. Because of the age of the data, our first recommendation in this sector is that the Secretary expedite the collection of recent ASC charge and cost data for the purpose of analyzing and revising the ASC payment system. Because there are no recent data on the cost of providing ASC services to Medicare beneficiaries, we looked at market factors and concluded that current payments for ASC services are more than adequate. The growth in the number of ASCs has been rapid: between 1997 and 2001, the number of Medicare-certified ASCs more than doubled. The volume of procedures provided by ASCs to beneficiaries increased by over 60 percent between 1997 and 2001. Over the last 10 years, the increase in payments is even more pronounced—in nominal dollars, payments have increased fourfold. In addition, as indicated by their rapid growth, ASCs have sufficient access to capital. Current Medicare payments for ASC services are at least adequate to cover next year’s expected increase in ASCs’ costs. Therefore, we recommend that the Congress not update the payment rates for ASC services for fiscal year 2004.

In addition, although costs in ASCs should be lower than in hospital outpatient departments because ASCs have less regulatory burden and serve less medically complex patients, the ASC rate is currently higher than the outpatient

hospital rate for several high-volume procedures. Therefore, we recommend the Congress ensure payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those same procedures after accounting for differences in the bundle of services covered.

Access to care

A basic goal of Medicare is to ensure that elderly and disabled Americans have access to appropriate, quality health care. Therefore, we plan to monitor three dimensions of beneficiaries' access to Medicare-covered services each year: (1) the health system's capacity, (2) beneficiaries' ability to obtain care, and (3) access to appropriate care. We do not find widespread problems in beneficiaries' access to care. Although more selective about accepting patients from a number of payers than in the past, the vast majority of physicians are accepting at least some new Medicare beneficiaries. Post-acute services are generally available, although it has become more difficult to place the most complex patients in SNFs. Nonetheless, some issues will require careful monitoring. As in other populations, certain beneficiaries—those in poor health, with low incomes, and without supplemental insurance—report more difficulty than others in accessing appropriate services. In addition, while the trend is improving, many beneficiaries are not receiving the most appropriate clinically recommended services. Finally, shortages of nurses could affect the availability or timeliness of certain services, and demographic trends raise concerns about the capacity of the health system over time.

Payment for new technologies

Medicare has the dual responsibility to pay enough for beneficial new technologies to ensure beneficiaries' access to care, while also being a prudent purchaser of new technologies. Prospective payment systems tend to promote the use of new technologies that reduce costs, but may slow adoption of technologies that increase costs. The inpatient and outpatient PPSs therefore, incorporate the costs of new technologies through special payment mechanisms as well as through an annual review of payment rates. To ensure fair treatment across technologies and payment systems, MedPAC recommends that the clinical criteria currently applied to all new technology applicants under the inpatient PPS, and to new medical device applicants under the outpatient PPS, be extended to new drugs and biologicals applicants under the outpatient PPS.

Health insurance choices for Medicare beneficiaries

Depending on where they live, Medicare beneficiaries may have a wide array of insurance options beyond traditional fee-for-service Medicare available to them. Those options may include Medicare+Choice comprehensive care plans and private fee-for-service plans, cost contract plans, preferred provider plans, and varying forms of supplemental coverage. Availability of options, and how and when beneficiaries choose among them, depends on specific market conditions and the circumstances of individual beneficiaries. The determinants of market conditions are both local and national. Although Medicare is a national program, it is only at the local level that medical care is delivered, beneficiaries choose insurance options and delivery systems, and insurers make decisions to enter the insurance market. In our report we review the entire spectrum of insurance choices, as a first step in MedPAC's effort to better understand beneficiaries' choices and market conditions.