

Report to the Congress:
Medicare Payment Policy

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Statement of
Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

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Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Chairman Johnson, Ranking Member Stark, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss MedPAC's March Report to the Congress and our recommendations on Medicare payment policy.

The Commission has become increasingly concerned with the trend of higher Medicare spending without a commensurate increase in value to the program. That trend, combined with the retirement of the baby boomers and Medicare's new prescription drug benefit, will, if unchecked, result in the Medicare program absorbing unprecedented shares of the GDP and of federal spending. Policymakers need to take steps now to slow growth in Medicare spending and encourage greater efficiency from health care providers. Medicare can and should take the lead in initiating changes to the health care system. But to encourage more thorough improvements in quality and efficiency, Medicare should work in collaboration with other payers.

Our March report to the Congress focuses on improving Medicare payment accuracy and calibrating payment adequacy to the efficient provider. The Commission reiterates its proposals to measure resource use and improve quality, to attain better value for the Medicare program. In this report, we review Medicare fee-for-service payment systems for eight sectors: hospital inpatient, hospital outpatient, physician, outpatient dialysis, skilled nursing, home health, long-term care hospitals, and inpatient rehabilitation facilities. Our analysis of payment adequacy for long-term care hospitals and inpatient rehabilitation facilities is the first for these sectors under their new prospective payment systems. The Commission's goal in all payment systems is for Medicare payments to cover the costs efficient providers incur in furnishing care to beneficiaries.

While this report focuses on Medicare's fee-for-service payment systems, our June 2005 report made recommendations on the Medicare Advantage program. Generally, these recommendations are intended to improve neutrality between the Medicare Advantage and fee-for-service program and among Medicare Advantage plans. The Commission strongly supports giving Medicare beneficiaries a choice to join private plans, because these plans have greater flexibility to improve the efficiency and quality of beneficiaries' health care services.

The Commission has long recommended that the program should be financially neutral as to whether beneficiaries join private plans or remain in fee-for-service Medicare.

We also recommend improvements to the process for determining relative values in the physician payment system and continue to evaluate the relative payments for different services within other prospective payment systems (PPSs). Last year we made recommendations on improving payment accuracy within the inpatient hospital and skilled nursing facility PPSs. We reiterate our recommendations on the SNF PPS in this report. For the inpatient payment system we recommended in our March 2005 report on specialty hospitals four steps to improve payment accuracy: refine the system to more fully capture differences in severity of illness, base relative weights on estimated cost instead of charges, base weights on the national average of hospitals' relative values, and adjust relative weights for prevalence of high-cost outlier cases.

Over the course of the last two years, the Commission has recommended that Medicare create incentives to improve quality through its payment systems. This approach builds upon the experience of private purchasers in designing and running pay-for-performance programs that reward health care providers for improving the quality of care. The Institute of Medicine and others have pointed to the quality gaps in the American health care system. While Medicare already has some programs in place to improve quality, these are not enough to orient the whole system towards improving quality; nor is it equitable for Medicare to pay a high quality provider the same as one that furnishes poor care.

Medicare should start differentiating among providers by paying more for higher quality performance and less for poor quality. This change to Medicare's payment systems is urgently needed. Currently, Medicare pays providers the same regardless of their quality. We have recommended pay-for-performance programs and that the Congress direct the Secretary to set quality standards for all providers who bill Medicare for performing and interpreting diagnostic imaging studies—which represents a major change in Medicare's payment policy. While some providers have raised concerns about aspects of a pay-for-performance program, these concerns must be weighed against the costs of not moving forward: allowing the program to reward poor care and not recognize quality care. Because Medicare is such an important part of

the American health care system, it can be very influential in transforming the incentives in the broader health care system.

The Commission has concluded that pay for performance is ready to move forward in five settings—hospital, physician, home health, Medicare Advantage, and end-stage renal disease. The Commission has also recommended that Medicare measure resource use of physicians and feed this information back confidentially to them. The Commission is exploring measurement of resource use and evaluating its use in pay-for-performance programs. These are important steps to improving quality for beneficiaries and laying the groundwork for obtaining better value in the Medicare program.

While these recommendations will improve the current payment systems, as the new prescription drug benefit begins, new types of private plans enter the program, and new payment systems go into effect, new patterns of care will result. In particular, the Commission is conducting research on how beneficiaries learned about the drug benefit and what factors were important to them as they made decisions to enroll or not enroll in plans. We are also compiling baseline information on plan offerings for 2006 including: what organizations are offering plans; what type of plan they are offering (basic versus enhanced); and variations in premiums and benefit structures, including cost sharing and formularies.

In future work the Commission will analyze these changes and make recommendations to the Congress on how the new programs can be improved to increase their value.

Context for Medicare payment policy

Health care spending has been rising more rapidly than growth in national income for many decades, and all indications suggest that it will continue to do so into the future. The continuation of this trend, combined with the retirement of the baby boomers and Medicare's new prescription drug benefit, will lead the Medicare program to require unprecedented shares of GDP and federal spending.

Policymakers need to take steps now to slow growth in Medicare spending and encourage greater efficiency from health care providers. Delaying taking action will require more drastic changes to the program in the future. Strategies to address Medicare's long-term sustainability include constraining payment rates for health care providers, changing eligibility and benefits,

increasing the program's financing, and encouraging greater efficiency from health care providers. The last strategy—increasing efficiency—is the most desirable because it would enable the Medicare program to do more with its resources. Even if policymakers succeed at moving providers towards greater efficiency, they may still need to make other policy changes to help ensure that the program is sustainable into the future.

Medicare and its beneficiaries are not alone in facing the challenges of rapid growth in health spending—all stakeholders in the U.S. health care system are confronting similar pressures. Medicare relies on providers and health plans that care for the entire population, not just Medicare beneficiaries, and thus broad trends in the health care system affect the environment in which the program operates. Medicare can and should take the lead in initiating changes to the health care system. But to encourage more thorough improvements in quality and efficiency, Medicare should collaborate with other payers. For example, Medicare could use comparative-effectiveness analysis more readily if other payers do so as well, and a common set of measures for quality and resource use across payers would reduce the reporting burden on providers and magnify the impact of any public and private incentive programs.

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

We make update recommendations for one year at a time so that we can assess payment adequacy with the latest data each year. We answer the question of whether current Medicare payments are adequate by examining information about beneficiaries' access to care; changes in the capacity, volume, and quality of care; providers' access to capital; and, where available, the relationship of Medicare payments to providers' costs. Our assessment of the relationship between Medicare payments and providers' costs is influenced by whether current costs approximate those of efficient providers. Efficient providers use fewer inputs to produce quality outputs.

We then account for expected cost changes in the next payment year, such as those resulting from changes in input prices. As part of those considerations, we incorporate our expectation for improvement in productivity (0.9 percent for 2007). Medicare payment rates to health care providers should be set so that the federal government benefits from providers' productivity gains, just as private purchasers of goods in competitive markets benefit from the productivity

gains of their suppliers. In developing its payment recommendations, MedPAC expects improvements in productivity consistent with the productivity gains achieved by the firms and workers who pay the taxes and premiums that support Medicare. The productivity factor is a policy objective, not an empirical estimate. To the extent that providers are unable to achieve this productivity target, that outcome would be revealed subsequently in MedPAC's analysis of payment adequacy, which is considered anew each year.

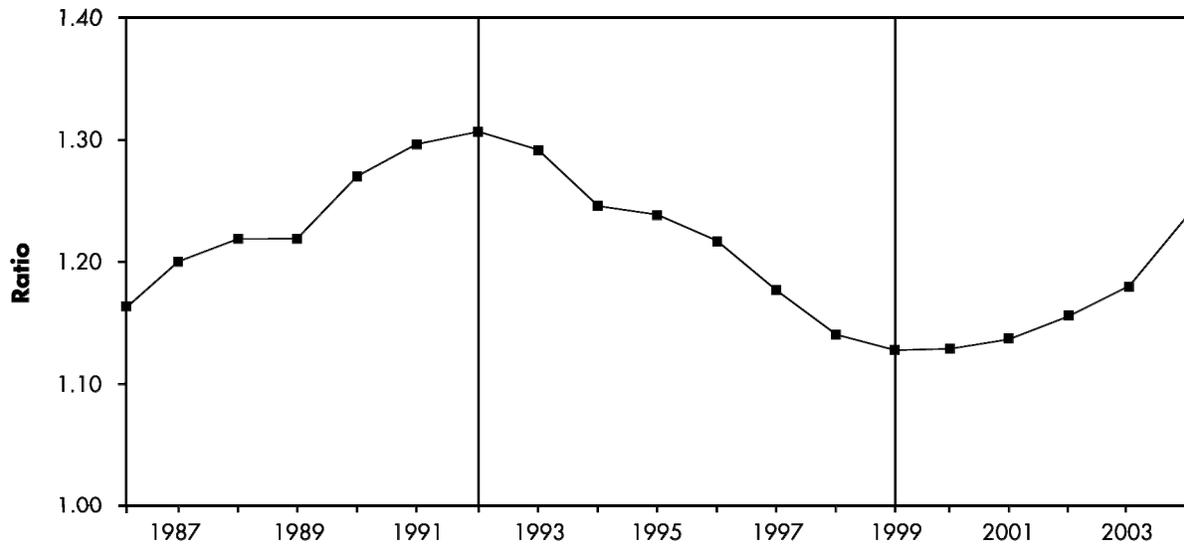
Hospital inpatient and outpatient services

Indicators of payment adequacy for hospitals present a mixed picture. Our assessments of beneficiaries' access to care, service volume growth, and access to capital are positive, while the results on quality are mixed. Regarding access to capital, hospital construction spending has been growing 15 percent annually since 1999 to an estimated \$23 billion in 2005. However, the Commission is concerned that hospitals' overall Medicare margins are negative and that hospitals have had unusually large cost increases in recent years.

The rate of cost growth has been affected by unusual cost pressures, but it also has been influenced by the recent lack of financial pressure from private payers. Hospital costs appear to be influenced by cycles in private sector profitability. From 1986 through 1992, most insurers still paid hospitals on the basis of their charges, with little price negotiation or selective contracting. With limited pressure from private payers, the ratio of private-payer payments to hospitals' costs increased rapidly (Figure 1). In the mid-1990s, HMOs and other private insurers began to negotiate more vigorously for better prices and the payment-to-cost-ratio for private payers declined from 1993 through 1999. By 2000 hospitals had regained the upper hand in price negotiations due to hospital consolidations and consumer backlash against managed care and restricted networks. Private payer payment rates rose rapidly and the payment-to-cost ratio for private payers rose from 2000 to 2004.

**FIGURE
1**

Three distinct periods in the private payer payment-to-cost ratio



Note: Data include all inpatient, outpatient, and post-acute hospital services.

Source: American Hospital Association annual survey of hospitals.

Cost growth during these same three periods followed the trends in private-payer profitability. In the last four years (2001 to 2004), increases in private-payer profitability were accompanied by hospital costs rising at a rate faster than the market basket of input prices.

In addition, our analysis suggests that more efficient hospitals may not be performing as poorly as the industry's aggregate margin would suggest. High-cost hospitals have a significant effect on the industry's financial performance under Medicare. To illustrate, removing the roughly one fifth of hospitals with consistently high costs in both 2002 and 2004 raises the margin forecast by more than 2 percentage points. In addition, hospitals with consistently negative Medicare margins had above-average costs and cost growth, and these hospitals are not competitive in their own markets as evidenced by having higher costs and lower occupancy than neighboring facilities.

Balancing the payment adequacy indicators and concern about trends in margins and efficiency, the Commission recommends an update of market basket minus half of our expectation for productivity growth for both inpatient and outpatient hospital services. These

updates should be combined with a quality incentive payment policy for hospitals and the improvements to the inpatient PPS relative values we recommended last year: refine the system to more fully capture differences in severity of illness, base relative weights on estimated cost instead of charges, base weights on the national average of hospitals' relative values, and adjust relative weights for prevalence of high-cost outlier cases. Although CMS has taken some steps to make payments more accurate for certain DRGs, ensuring payment accuracy across the board is necessary to make payments equitable and to lessen inequities resulting from selection.

Physician services

Our analysis of beneficiary access to physician care, physician supply, Medicare-to-private fee level comparisons, and the growth in physician service volume finds that many of these indicators are stable and shows that the large majority of beneficiaries are able to obtain physician care. Beneficiaries' access to physicians is similar to, or even better than, access for those with private insurance and has been stable. Averaged across all services and areas, the ratio of Medicare payment rates versus private payment rates rose slightly from 2003 to 2004. Additionally, the volume of services used per beneficiary continues to grow significantly, which has led to considerable spending increases. In consideration of expected input costs for physician services and our payment adequacy analysis, the Commission recommends that the Congress increase payments for physician services by the projected change in input prices less our expectation for productivity growth for 2007.

In contrast to this recommendation, current law calls for substantial negative updates from 2007 to 2011, under the sustainable growth rate (SGR) formula. The Commission does not support these sustained fee cuts because they could threaten beneficiary access to physician services. The Commission is especially concerned about the effect of rate cuts on access to services provided by primary care physicians and in the longer term about the attractiveness of primary care to new physicians. Furthermore, the Commission considers the SGR formula a flawed, inequitable mechanism for volume control. Over the next year, the Commission will examine alternatives to the SGR formula as mandated by the Deficit Reduction Act of 2005.

Valuing services in the physician fee schedule

Relative value units (RVUs) are a key element of Medicare’s physician fee schedule. They determine how payment rates vary among the more than 7,000 services that physicians furnish to the program’s beneficiaries. Periodic review of RVUs is important because the resources needed to perform a service can change over time. When that happens, the value of a service must be changed accordingly; otherwise, Medicare’s payments will be either too high or too low.

Because the current system does a poor job of identifying overvalued services, we recommend improvements to the process for determining relative rates paid for services in the physician payment system. Inaccurate rates distort the market for physician services, and the Commission is concerned that in the long run they may affect the supply of physicians—in particular those providing primary care services. The Commission recommends improvements to the process that will help reduce the number of physician fee schedule services that are misvalued, thereby making payment more accurate.

The Commission recommends that the Secretary establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the American Medical Association’s Relative Value Scale Update Committee (RUC), and that the Congress and the Secretary ensure that this panel has the resources it needs to independently collect data and develop evidence. In consultation with this expert panel, the Secretary should initiate reviews for services that have experienced substantial changes in factors that may indicate changes in physician work and identify new services likely to experience reductions in value. Those latter services should be referred to the RUC and reviewed in a time period as specified by the Secretary. Finally, to ensure the validity of the physician fee schedule, the Secretary should review all services periodically.

Outpatient dialysis services

Most indicators of payment adequacy for outpatient dialysis services are positive. Beneficiaries are not facing systematic problems in accessing care. Providers are increasing capacity to meet patients’ demand (as demonstrated by the increasing number of facilities and hemodialysis treatment stations), spending is increasing, and providers have sufficient access to capital. The

quality of care is improving for some measures—dialysis adequacy and anemia status—and unchanged for others. Although most of the indicators for payment adequacy are positive, the Commission is concerned about the trend and level of Medicare margins for outpatient dialysis services. Balancing these considerations, the Commission recommends increasing the composite rate in 2007 by the projected rate of increase in the end-stage renal disease market basket less half of the Commission’s expectation for productivity growth.

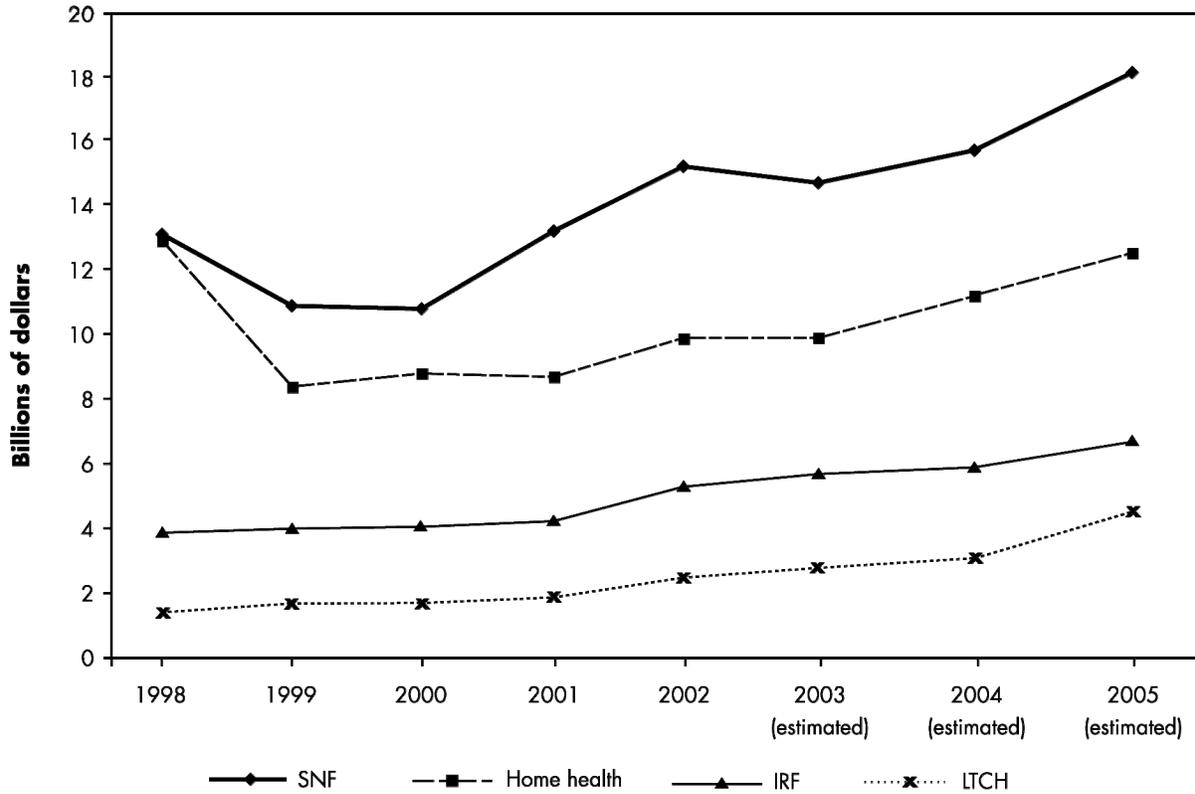
In addition to updating the composite rate, to improve equity in payments between provider types the Commission reiterates its recommendation that the Congress eliminate payment differences between freestanding and hospital-based facilities for composite rate services and combine the composite rate and the add-on payment.

Post-acute care providers

The recuperation and rehabilitation services that post-acute care providers furnish are important to Medicare beneficiaries. Medicare spending on post-acute care services totaled about \$36 billion in 2004, accounting for more than 12 percent of total Medicare spending. After slowing in the late 1990s when CMS implemented the Balanced Budget Act of 1997, spending and the number of providers have risen (Figure 2). The number of home health agencies increased by 10 percent in the last year alone, and there were over 50 percent more long-term care hospitals in 2005 than in 2000. The rise in spending is the result of both higher payments and greater use.

FIGURE 2

PAC spending shows recent growth



Note: PAC (post-acute care), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). These amounts are program spending only; they do not include beneficiary copayments.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

We have analyzed payment adequacy for each of the four types of post-acute care providers: skilled nursing facilities (SNFs), home health agencies, long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). The payment systems for all four of these providers face similar issues:

- payments are not well calibrated to costs,
- services overlap among settings,
- the post-acute care product is not well defined, and
- assessment instruments differ among settings.

These issues make it difficult to get better value for Medicare spending across the spectrum of post-acute care.

New prospective payment systems for post-acute care providers have led to changes in the patterns of post-acute care use, which may not serve the program or beneficiaries well. We have called for action to slow payments, refine the case-mix systems, and measure quality of care. However, even refining all of the case-mix systems would still not resolve issues of whether patients go to the right post-acute care setting or whether they need post-acute care at all. There is still a need for comprehensive payment system reform across all PAC settings.

Skilled nursing facility services

Most indicators of payment adequacy for SNFs—access to care, supply, spending, quality, access to capital—are stable, and the volume of services continues to increase. In addition, the Medicare margin for SNFs continues to be high and SNF payments appear more than adequate to accommodate cost growth. Therefore, the Commission recommends that the Congress eliminate the update to payment rates for skilled nursing facility services for fiscal year 2007.

CMS's refinements to the SNF case-mix system in 2006 did not address long-standing problems with the allocation of SNF payments. Therefore, the Commission once again recommends that the Secretary modify the SNF PPS to more accurately capture the cost of providing care to different types of patients. This new system should: reflect clinically relevant categories of patients, more accurately distribute payments for nontherapy ancillary services, improve incentives to provide rehabilitation services based on the need for therapy, and be based on more contemporary data than the current system. We will continue work to further define such a new system.

Currently, CMS has only three quality indicators for SNF patient care, all of which are limited. Medicare urgently needs quality indicators that allow the program to assess whether patients benefit from SNF care and to distinguish between facilities. The Commission recommends that CMS:

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

Home health services

Evidence suggests that access to home health services is good: communities across the country have providers and more providers are entering the program. In addition, the quality of care continues to improve slightly, and the number of users and the amount of services that they use are rising. These factors, along with more than adequate margins, suggest that agencies should be able to accommodate cost increases over the coming year without an increase in base payments. Therefore, the Commission recommends that the Congress eliminate the update to payment rates for home health care services for calendar year 2007.

The Commission continues to be concerned about aspects of this payment system. There is some evidence that payments are not being distributed accurately within the system. The number of visits per episode and the mix of the type of visits (therapy, skilled nursing, and aide) have changed substantially since the payment system was developed and hence, the payment system may not now accurately predict the relative costliness of episodes. Ideally, the system's adjustments should bring payments closer to costs. The Commission will continue to investigate improvements to the payment system.

Long-term care hospital services

This year, for the first time under the new prospective payment system, the Commission assesses the adequacy of payment for long-term care hospitals. LTCHs provide care to patients with clinically complex problems who need hospital-level care for extended periods of time. Medicare is the predominant payer for long-term care hospital services.

Medicare payments for LTCH services are more than adequate. The supply of LTCHs, the volume of services, and the number of beneficiaries admitted to LTCHs have all increased rapidly since 2001. Changes in quality are mixed and access to capital is good. Moreover, Medicare spending for these facilities increased twice as fast as volume, and in 2004 alone, spending increased almost 38 percent. This increase is due in part to patients being assigned to higher payment categories—some because of increases in patient complexity and some because of coding improvements. Margins in this sector have been high.

The Commission concludes that long-term care hospitals should be able to accommodate cost changes in 2007 and therefore recommends that the Congress eliminate the update to payment rates for LTCH services for 2007.

Inpatient rehabilitation facility services

This year, also for the first time under the new prospective payment system, the Commission is assessing the adequacy of payment for inpatient rehabilitation facilities. IRFs provide intensive rehabilitation services. To be eligible for treatment in an IRF, beneficiaries must be able to tolerate and benefit from three hours of therapy per day.

Indicators of payment adequacy were generally positive through 2004. Supply and volume increased, quality was stable, and access to capital was good. Medicare payments grew rapidly from 2002 to 2004, resulting in high margins for IRFs. Regulatory changes and industry trends complicate analysis of this sector affecting both volume of services and financial performance. However, we estimate margins will still be more than adequate and that IRFs can accommodate price changes without an increase in payments. Therefore, the Commission recommends that the Congress eliminate the update to payment rates for inpatient rehabilitation facility services for fiscal year 2007.