CHAPTER 2

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

RECOMMENDATIONS

Section A: Hospital inpatient and outpatient services

2A-1 The Secretary should add 13 DRGs to the post-acute transfer policy in fiscal year 2004 and then evaluate the effects on hospitals and beneficiaries before proposing further expansions.

***YES: 15 • NO: 1 • NOT VOTING: 1 • ABSENT: 0**

2A-2 The Congress should enact a low-volume adjustment to the rates used in the inpatient PPS. This adjustment should apply only to hospitals that are more than 15 miles from another facility offering acute inpatient care.

YES: 17 • NO: 0 • NOT VOTING: 0 • ABSENT: 0

2A-3 The Secretary should reevaluate the labor share used in the wage index system that geographically adjusts rates in the inpatient PPS, with any resulting change phased in over two years.

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

2A-4 The Congress should raise the inpatient base rate for hospitals in rural and other urban areas to the level of the rate for those in large urban areas, phased in over two years.

YES: 17 • NO: 0 • NOT VOTING: 0 • ABSENT: 0

2A-5 The Congress should raise the cap on the disproportionate share add-on a hospital can receive in the inpatient PPS from 5.25 percent to 10 percent, phased in over two years.

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

2A-6 The Congress should increase payment rates for the inpatient PPS by the rate of increase in the hospital market basket, less 0.4 percent, for fiscal year 2004.

YES: 17 • NO: 0 • NOT VOTING: 0 • ABSENT: 0

2A-7 The Congress should increase payment rates for the outpatient PPS by the rate of increase in the hospital market basket, less 0.9 percent, for calendar year 2004.

YES: 17 • NO: 0 • NOT VOTING: 0 • ABSENT: 0

Section B: Physician services

2B The Congress should update payments for physician services by the projected change in input prices, less an adjustment for productivity growth of 0.9 percent, for 2004.

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

Section C: Skilled nursing facility services

2C-1 The Secretary should continue a series of nationally representative studies on access to skilled nursing facility services (similar to studies previously conducted by the Department of Health and Human Services' Office of Inspector General).

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

2C-2 The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2004.

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

2C-3A Consistent with previous MedPAC recommendations, the Secretary should develop a new classification system for care in skilled nursing facilities.

Because it may take time to develop this system, the Secretary should draw on new and existing research to reallocate payments to achieve a better balance of available resources between the rehabilitation and nonrehabilitation groups.

To allow for immediate reallocation of resources, the Congress should give the Secretary the authority to:

- remove some or all of the 6.7 percent payment add-on currently applied to the rehabilitation RUG–III groups.
- reallocate money to the nonrehabilitation RUG–III groups to achieve a better balance of resources among all of the RUG–III groups.

2C-3B If necessary action does not occur within a timely manner, the Congress should provide for a market basket update, less an adjustment for productivity growth of 0.9 percent, for hospital-based skilled nursing facilities to be effective October 1, 2003.

YES: 17 • NO: 0 • NOT VOTING: 0 • ABSENT: 0

***COMMISSIONERS' VOTING RESULTS**

Section D: Home health services

2D-1 The Secretary should continue a series of nationally representative studies on access to home health services (similar to studies previously conducted by the Department of Health and Human Services' Office of Inspector General).

***YES: 16 • NO: 0 • NOT VOTING: 0 • ABSENT: 1**

2D-2 The Congress should extend for one year add-on payments at 5 percent for home health services provided to Medicare beneficiaries who live in rural areas.

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

2D-3 The Congress should eliminate the update to payment rates for home health services for fiscal year 2004.

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

Section E: Outpatient dialysis services

2E The Congress should update the composite rate payment by the projected change in input prices, less 0.9 percent, for calendar year 2004.

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

Section F: Ambulatory surgical center services

2F-1 The Secretary should expedite collection of recent ASC charge and cost data for the purpose of analyzing and revising the ASC payment system.

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

2F-2 The Congress should eliminate the update to payment rates for ASC services for fiscal year 2004.

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

2F-3 Until the Secretary implements a revised ASC payment system, the Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those procedures, after accounting for differences in the bundle of services covered.

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

***COMMISSIONERS' VOTING RESULTS**

CHAPTER 2

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

In this chapter

- Hospital inpatient and outpatient services
- Physician services
- Skilled nursing facility services
- Home health services
- Outpatient dialysis services
- Ambulatory surgical center services

The law requires MedPAC to develop payment update recommendations for each major service sector in fee-for-service Medicare. While the process of setting updates is inherently imperfect, we have developed a framework to help us formulate our recommendations in the most thoughtful and consistent way possible. Our model breaks the process into two parts: assessing the adequacy of current Medicare payments and accounting for the increase in efficient providers' costs in the coming year. We also take current law into account. We applied our updating model to services in seven sectors: hospital inpatient, hospital outpatient, physician, skilled nursing facility, home health, outpatient dialysis, and, for the first time, ambulatory surgical center. Generally we found that current payments are at least adequate—and in some cases more than adequate—in these sectors. For physician payments, however, our finding of adequate payments is linked to Congressional action to provide a modest increase in payments for 2003.

The goal of Medicare payment policy is to align payments with efficient providers' marginal costs of furnishing health care, and in so doing to help ensure beneficiaries' access to high-quality services. Achieving this goal involves setting the base payment rate (for services of average complexity) at the right level, developing payment adjustments to accurately reflect cost differences among types of services and for varying market conditions, and then annually considering the need for a payment update.

MedPAC's general approach to payment policy attempts to:

- make enough funding available for paying providers to preserve Medicare beneficiaries' access to high-quality care, and
- distribute payments accurately across services and among providers in different health care markets.

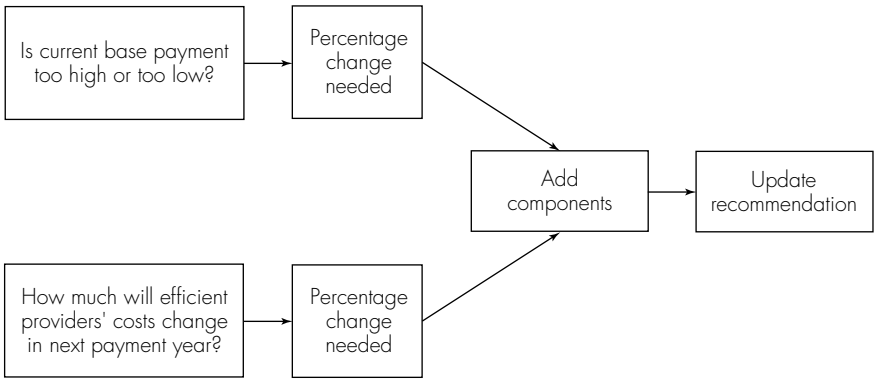
The Commission's annual update decisions address the first of these objectives. Other recommendations address distributional issues. Often these will coincide with the updating process because policy changes affecting the distribution of payments can also affect the overall amount of payments.

In practice, we have no way of measuring providers' marginal costs or determining the costs associated with efficient operation. But the law nonetheless requires MedPAC to develop payment update recommendations for each major service sector in fee-for-service Medicare. Consequently, we have developed a framework to guide our update decision making, so as to carry out this inherently imperfect process in the most thoughtful and consistent way possible.

In our model, we sequentially address two questions that together determine the appropriate level of aggregate funding for a given payment system:

- Is the current base payment rate too high or too low?
- How much will efficient providers' costs change in the next payment year?

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



As shown in Figure 2-1, if the current base rate is too high or too low, we will recommend a compensating percentage change factor, and we recommend a second percentage change factor to account for cost changes expected during the forthcoming year. The two are then summed to produce our recommended update. As a practical matter, the Commission may not publish these percentage factors separately, but we consider both questions in arriving at our final update recommendation.

This section of the chapter begins by reviewing the basics of our two-part system and then discusses two special issues in updating payments:

- taking current law into account, and
- considering the impact of new technology pass-through payments.

The chapter then proceeds through the Commission's analysis of payment adequacy and development of update and other recommendations for hospital inpatient and outpatient, physician, skilled nursing facility, home health, outpatient dialysis, and ambulatory surgery services.

Model for assessing payment adequacy and updating payments

Our model attempts to separate assessing the adequacy of current payments from projecting likely changes in efficient providers' costs for the coming year because commingling these processes has caused confusion in the past. For example, one of the factors the Commission believed was responsible for hospital payments being too high in the 1990s was unbundling of the payment unit. Hospitals shifted care at the end of patients' acute inpatient stays to other settings, such as rehabilitation or skilled nursing facilities, which reduced hospitals' costs. The Commission's decision to recommend reduced updates in response to this phenomenon brought charges that the updates would not adequately cover hospital cost inflation. Publishing the reduction as a response to current payments being too high—separate from an allowance for cost growth in the coming year—might have presented a clearer picture of the rationale for our recommendation.

Multiple factors can contribute to a gap between current payments and costs, including errors in past forecasts of input price inflation, changes in coding practices, unbundling of the payment unit,

or other changes in product. The most important issue for our attention is *whether* payments are too high or too low, as opposed to *how* they became so. But when we believe that a specific factor may have played a major role in making payments too high or too low—particularly in the most recent year—developing an estimate of the effect of that factor may help in deciding whether and how much to adjust for the adequacy of current payments.

Part one: assessing payment adequacy

The first part of MedPAC's approach to developing payment updates is to assess the adequacy of current payments. In most cases, we address payments for the services covered by a single payment system (for example, home health or physician services). When a single organization provides services across multiple payment systems, however, cross-subsidization and inaccurate allocation of costs among services may distort our measures of payments and costs. The prime examples of this phenomenon are hospitals (that provide acute inpatient, outpatient, home health, skilled nursing, and inpatient rehabilitation and psychiatric services) and dialysis facilities (that provide dialysis treatments and furnish separately billable medications to dialysis patients).

In these instances, we assess the adequacy of payments for all the Medicare services that one type of provider furnishes. If we decide that payments in aggregate are too high or too low, we must then also decide how to distribute the resulting change among services. We would do this by adjusting one or more of the applicable base rates.

As discussed below, MedPAC's approach to assessing the adequacy of current Medicare payments includes three steps:

- estimating current payments and costs,
- assessing the adequacy of current payments relative to costs, and
- adjusting current payments via an update or distributional change (Figure 2-2).

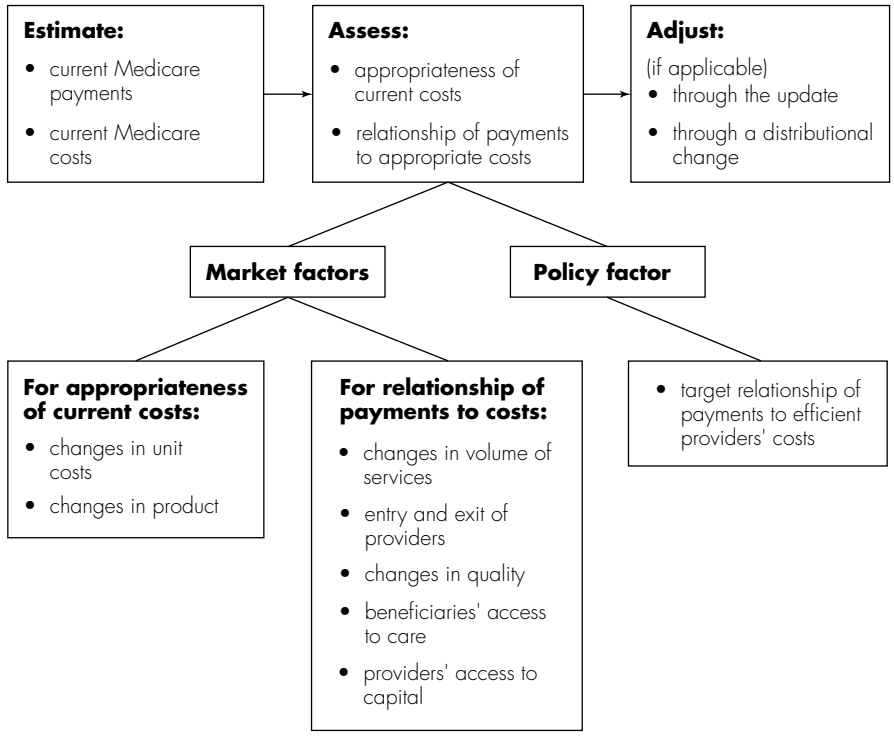
Estimating current payments and costs

We begin our assessment by estimating total Medicare payments nationally, along with the corresponding provider costs of treating Medicare beneficiaries. The relationship between costs and payments is typically expressed as a margin.[1] The base margin estimate covers the year preceding the one to which our update recommendation will apply. In this report, we are estimating payments and costs for fiscal year 2003 to inform our update recommendations for fiscal year 2004.

Unfortunately, because of processing delays caused by changes in the format of Medicare cost reports, the latest data available to us from providers' cost reports are from fiscal year 2000. Consequently, we have estimated the changes in both Medicare's payments and providers' costs (assuming a constant volume of service) from 2000 to 2003.

On the payment side, we first apply the annual payment updates specified in law for 2001 through 2003 to our 2000 base numbers. We then model the effects of other policy changes that will affect the level of payments during this three-year period. For changes other than updates, we also include provisions scheduled to go into effect in the decision year (fiscal or calendar year 2004).[2] This allows us to consider whether current payments would be adequate under all applicable provisions of current law. Thus, we end up with estimates of what payments in

FIGURE 2-2 **Steps and factors in assessing payment adequacy**



1 A margin is calculated as payments less costs divided by payments. Alternatively, the data can be expressed as a ratio of payments to costs.

2 An example of a payment policy scheduled to go into effect in 2004 is eliminating the hold-harmless provision for small rural hospitals under the outpatient prospective payment system.

fiscal year 2003 would have been, had fiscal year 2004 payment rules been in effect.

On the cost side, we estimate the increases in costs per unit of output over the same three-year period—a difficult task given that fiscal year 2003 had just started when we had to make our decisions. Generally we assume that cost per unit of output has increased at the rate of input price inflation, as measured by the applicable market basket index from the Centers for Medicare & Medicaid Services (CMS), adjusted downward slightly in anticipation of productivity improvments.[3] In some cases, however, more recent estimates of cost growth are available through claims analysis and alternative data sources such as the National Hospital Indicators Survey, which CMS and MedPAC cosponsor.

Assessing the adequacy of current payments relative to costs

The next step in assessing payment adequacy involves two interrelated issues:

- the appropriateness of providers' costs (that is, whether actual costs provide a reasonable representation of the costs of efficient providers), and
- the relationship of payments to an appropriate cost base.

In examining the cost base (aggregate current costs), we generally treat the volume of services as given. At a certain volume, providers' total costs are driven by the average cost per unit of output, which then becomes the focal point of our analysis. If this unit cost is considered appropriate, we then proceed to the question of whether payments are adequate to cover costs and to provide sufficient funds for keeping plant and equipment up to date. However, if costs are too high (implying some degree of inefficiency) or too low (implying that additional spending is needed to ensure appropriate quality and access to care), then an adjustment to actual costs may be needed before we decide whether payments are adequate in relation to those costs.

The tasks of assessing the appropriateness of the cost base and the adequacy of payments inevitably require Commission judgment. Available information is invariably limited. Nonetheless, several types of data about the market conditions that providers face may provide useful clues (Figure 2-2).

Market factors Two market factors relate primarily to the appropriateness of current costs:

- the trend in average cost per unit of output, and
- evidence of change in the product being furnished.

Although it is nearly impossible to know whether costs are "efficient" in the absolute, the rate of change in unit costs at least provides evidence of whether the initial level of appropriateness has been maintained. Other things being equal, we would generally expect average growth in unit costs to approximate the rate of increase in the applicable market basket index, or be slightly below the market basket increase with productivity improvements. Changes in product can have a major effect on unit costs, however. For example, substantial reductions in the length or visit content of home health episodes would be expected to reduce the growth in provider costs (inflation adjusted).

Changes in several other market factors may suggest that payments are too high or too low relative to costs, even in the absence of any direct evidence as to whether the cost base is appropriate (Figure 2-2):

- changes in the volume of services,
- entry or exit of providers,
- changes in the quality of care,
- changes in beneficiaries' access to care, and
- changes in providers' access to capital.

Reductions in the volume of services furnished or in the number of providers offering services to Medicare beneficiaries may indicate that revenue flows are inadequate for providers to continue operating or to provide the same level of services. Facilities closing is the extreme outcome, although it can be difficult to distinguish between closures that have serious implications for access to care in a community and those that have resulted from excess capacity. Evidence that more privately practicing physicians are refusing to accept new Medicare patients is another example. By the same token, substantial increases in volume or the number of providers may indicate that payments are more than sufficient to cover providers' financial needs, potentially leading to unnecessary services being provided.[4]

Although difficult to measure, deteriorating quality or access to care may indicate that revenues (either specific to Medicare or across all payers) are inadequate. It is unlikely, however, that quality measures alone would ever provide the basis for concluding that Medicare payments are too high. Changes in bond ratings may indicate that providers' access to needed capital has deteriorated or improved, although the data are difficult to interpret because access to capital depends on more than just bond ratings. The industry's volume of borrowing and overall level of capital expenditures may provide indirect evidence of access to capital.

3 Actual changes in the market basket index were used for 2002 together with CMS's forecasts of the market basket for 2003.

4 Changes in the volume of physician services must be interpreted cautiously because in this case there is some evidence to suggest that volume goes up when payment rates go down—the so-called "volume offset."

Policy factor Apart from market factors, there is a policy factor to be considered when assessing the adequacy of current Medicare payments—namely, the desired relationship between payments and costs (Figure 2-2). Given a judgment that the current level of costs is appropriate, a target ratio of payment to costs could simplify MedPAC's assessment of payment adequacy—if our projection of current year payments and costs produced a margin above the target, then we would recommend a downward adjustment, and vice versa.

The appropriate margin of payments over appropriate costs—which could be a narrow range, rather than a specific point—is difficult to discern. Difficulty arises for several reasons: the degree of risk among specific providers varies depending on their size, the actions of other payers, their exposure to nonpaying patients, and other factors. Even on average across all providers, however, risk could vary by sector and over time for a given sector. Moreover, even if we could identify a target aggregate margin, it would still be only one element of a composite picture that is also informed by the other factors described above (the effects of changes in product, quality of care, access to care, and so forth).

In sum, our deliberations have suggested that it will not be possible to develop a *standard* relationship between payments and appropriate costs. Thus, the Commission will still need to think about an appropriate range for this relationship each year, one sector at a time.

Adjusting current payments via an update or distributional change

A finding that current Medicare payments are too high or too low will lead to an adjustment to the payment update that otherwise would apply. If the adjustment is large, the Commission typically recommends phasing it in over two or more years. Sometimes, however, we may find it appropriate to increase or decrease the amount of money in the system in a way that simultaneously redistributes payments. In this case, we would intend the combined impact of the distributional changes and the update itself to provide for an appropriate level of payments in the policy year.

It may be useful to quantify a percentage adjustment factor when we find that current payments are too high or too low. Often, however, the Commission simply makes clear that current payments are too high or too low and then considers that finding together with the expected cost change in the coming year (as discussed below) in developing its update recommendation.

Part two: accounting for providers' cost changes in the coming year

The second part of MedPAC's approach to developing payment update recommendations is to account for expected cost changes in the next payment year. This involves reviewing evidence about the likelihood and extent of changes in factors that are expected to affect providers' costs. One major factor is change in input prices, as measured by the applicable CMS price index. For institutional providers, we use the forecasted increase in an industry-specific index of national input prices, called a market basket index. For physician services, we use a similar index known as the Medicare Economic Index. 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 remain constant. Several other factors may also affect providers' costs in the coming year:

- *Scientific and technological advances*—Many improvements in medical science and technology enhance quality and reduce providers' costs (or leave costs unchanged). No increase in Medicare's payment rates is needed to accommodate these changes because providers have a financial incentive to adopt them. But we should consider the effects of technological advances that improve quality of care and also increase costs, when these effects are substantial and the technologies are broadly disseminated. The Commission monitors industry trends and has informal discussions with industry representatives in each service area. When evidence suggests that one or more technological advances in a specific area are playing an unusually large role in increasing providers' costs, we may attempt to estimate the cost impact of these advances.
- *Improvements in productivity*—The Commission believes that providers should be able 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. Productivity gains are often achieved by adopting new technology. We have adopted the long-term growth rate for productivity in the general economy as our standard of expected productivity improvement. Specifically, we use the 10-year average annual change in total-factor productivity as published by the U.S. Bureau of Labor Statistics, which is currently estimated at 0.9 percent.
- *One-time factors*—On occasion, we recommend an adjustment to the update to reflect a one-time factor that has a systematic and substantial effect on costs and will improve care for beneficiaries or is necessary for another reason (such as a legal mandate). Examples of one-time factors the Commission has taken into account in the past include Medicare's share of the 2000 computer problem and the cost of complying with the Health Insurance Portability and Accountability Act of 1996.

We generally consider the estimate of input price inflation as the most important factor influencing providers' costs, particularly since the costs of

technological advances and improvements in productivity at least partially offset each other. This focus on inflation also reflects the reality that the costs of new technology and productivity gains are difficult to measure. To the extent that important changes do not get addressed when we update payments in a given year, their effects can be considered in our analysis of payment adequacy in the next cycle.

Special issues in updating payments

This section addresses two special issues that have arisen this year for assessing payment adequacy and updating payments: considering the budget implications of potential changes to current law and considering the impact of technology pass-through payments.

Budget implications

The Commission is aware of—and we document in our report—how spending under our recommendation would compare to that under current law. We begin by developing a list of current law provisions and changes scheduled to go into effect in the coming year, by sector, to illustrate any differences between MedPAC recommendations and present policy. We also develop rough estimates of the impact of recommendations relative to the current budget baseline, placing each recommendation into one of several categories. (Our method of documenting the budget implications of recommendations is discussed in greater detail in Chapter 1.)

Considering the impact of technology pass-through payments

For hospital outpatient and inpatient payments, Medicare makes additional payments for specific new technologies that have a substantial impact on provider costs. These payments are intended to be temporary, to ensure that Medicare can pay for a new or substantially improved technology during its initial diffusion period and until its effects on providers' costs can be reflected in the payment weights for the affected groups of patients or procedures.[5] After two to three years, during which necessary coding changes are implemented and charge data are collected from providers, permanent adjustments will be made to the relative payment weights and the temporary payment adjustments stopped.

It may be necessary to take technology pass-through payments into account in the second part of our update framework—the allowance for expected increases in efficient providers' costs. However, the impact of pass throughs on the overall level of payments will depend on whether they have been implemented in a budget neutral fashion.

If the payment adjustments are not budget neutral, which was the case initially with the outpatient pass-through payments, then they will augment the payment increase provided by the update. This means that any allowance for technological advancement in our update need only consider major technological cost impacts that are outside the scope of the pass-through system. The effect will be greatest in the first years after pass-through payments are implemented, when new technologies are approved for payment adjustments and there are not existing pass-through technologies ready to be folded into the prospective payment system rates. In later years, the impact on aggregate payments each year will be the net of new adjustments added and current adjustments eliminated.

If payments are made budget neutrally, which is the case now for both the outpatient and inpatient pass-through payments, then the net increase in costs resulting from the technologies should be considered in developing payment updates—but only if they are substantial and systematic. The data from the pass-through payments (utilization and payment rate for each technology) may provide useful input into the decision on how the impact of cost-increasing new technologies compares to expected productivity improvement. However, there are several limitations on how well aggregate pass-through payments will represent the overall impact of cost-increasing new technology, such that the data must be used guardedly. A detailed discussion of the treatment of new technology in Medicare's payment systems is presented in Chapter 4 ■.

5 These are ambulatory payment classification (APC) groups for outpatient payments and diagnosis related groups (DRGs) for inpatient payments.