CHAPTER 2

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

RECOMMENDATIONS

Section 2A: Hospital inpatient and outpatient services

2A The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2007 by the projected increase in the hospital market basket index less half of the Commission's expectation for productivity growth.

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

Section 2B: Physician services

2B The Congress should update payments for physician services in 2007 by the projected change in input prices less the Commission's expectation for productivity growth.

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

Section 2C: Outpatient dialysis services

2C-1 The Congress should update the composite rate in calendar year 2007 by the projected rate of increase in the end-stage renal disease market basket index less half the Commission's expectation for productivity growth.

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

2C-2 The Congress should direct the Secretary to: eliminate differences in paying for composite rate services between hospital-based and freestanding dialysis facilities; and combine the base composite rate and the add-on adjustment.

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

CHAPTER 2

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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 (2006). Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2007). Finally, we make a judgment as to what, if any, update is needed. When considering whether payments in the current year are adequate, we account for policy changes (other than the update) that are scheduled to take effect in the policy year under current law. This year we make update recommendations in eight sectors: hospital inpatient, hospital outpatient, physician, skilled nursing facility (SNF), home health, outpatient dialysis, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). The analyses of payment adequacy by sector are in the sections that follow and in Chapter 4. ■

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 resource use and preserving equity among both providers and beneficiaries. Necessary steps toward achieving this goal involve:

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

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

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

- Are payments at least adequate for efficient providers in 2006?
- How will efficient providers' costs change in 2007?
- How should Medicare payments change in 2007?

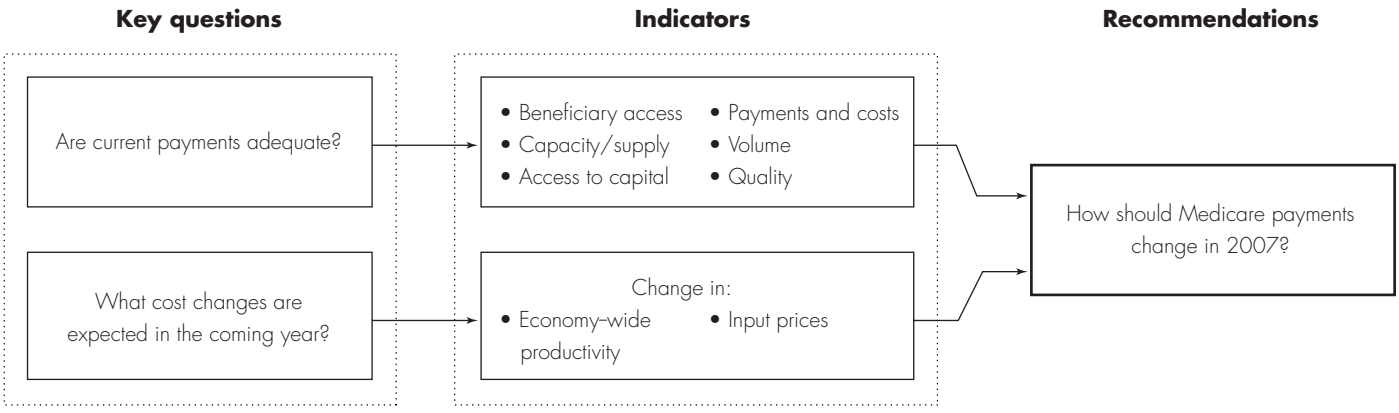
Efficient providers use fewer inputs to produce quality outputs. In the first part of our adequacy assessment, we judge whether Medicare payments are too high or too low compared with efficient providers' costs in the current year—2006. In the second part, we assess how we expect efficient providers' costs to change in the policy year—2007. Within a level of aggregate funding, we may also consider changes in payment policy that would affect the distribution of payments and improve equity among providers or improve equity and access to care for beneficiaries. We then recommend updates and other policy changes for 2007. This analytic process is illustrated in Figure 2-1.

Are Medicare payments adequate in 2006?

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

- 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 2006

FIGURE 2–1 **Payment adequacy framework**



Some measures focus on beneficiaries (for example, access to care) and some on providers (for example, the relationship of payments and costs in 2006). We consider multiple measures because the direct relevance, availability, and quality of each type of information varies among sectors, and no one measure provides all the information needed for the Commission to judge payment adequacy.

Beneficiaries' access to care

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

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

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

Substantial increases in the number of providers may suggest that payments are more than adequate and could raise concerns about the value of the services being furnished. For instance, rapid growth in the number of home health agencies could suggest that Medicare's payment rates are at least adequate and potentially more than adequate. If Medicare is not the dominant payer, changes in the number of providers may be influenced more by other payers and their demand for services and thus may be difficult to relate to Medicare payments.

When facilities close, we try to distinguish between closures that have serious implications for access to care in a community and those that may have resulted from excess capacity.

Changes in the volume of services

An increase in the volume of services beyond that expected for the increase in the number of beneficiaries could suggest that Medicare's payment rates are too high. Reductions in the volume of services, on the other hand, may indicate that revenues are inadequate for providers to continue operating or to provide the same level of services. Changes in the volume of services are often difficult to interpret because increases or decreases also could be explained by other factors, such as incentives in the payment system, population changes, changes in disease prevalence among beneficiaries, technology, practice patterns, and beneficiaries' preferences. In particular, changes in the volume of physician services must be interpreted 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 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. Quality is influenced by many factors, 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 (such as unnecessary complications) may result in additional payments. The influence of Medicare's payments on quality of care may also be limited when Medicare is not the dominant payer. However, the program's quality improvement activities can influence the quality of care for a sector. Changes in quality are thus a limited indicator of Medicare payment adequacy. In addition, increasing payments through an update for all providers in a sector regardless of their individual quality may not be an appropriate response to quality problems in a sector, particularly if other factors point to adequate payments. The Commission supports linking payment to quality to hold providers accountable for the care they furnish as discussed in our March 2004 and 2005 reports (MedPAC 2004, 2005).

Providers' access to capital

Access to capital is necessary for providers to maintain and modernize their facilities and capabilities for patient care. An inability to access capital that was widespread throughout a sector might in part reflect on the adequacy of Medicare payments (or in some cases, even on the expectation of changes in the adequacy of Medicare payments). However, access to capital may not be a useful indicator of the adequacy of Medicare payments when the sector has little need for capital, there is a perception of high regulatory risk, or providers derive most of their payments from other payers or other lines of business. For example, the majority of hospital and skilled nursing facility (SNF) revenues come from private sources (such as health insurance) or other government payers (such as Medicaid).

We examine access to capital for both nonprofit and for-profit providers. Changes in bond ratings may indicate that access to needed capital for nonprofit entities has deteriorated or improved, although the data are difficult to interpret because access to capital depends on more than just bond ratings. We also use indirect measures that can demonstrate providers' access to capital, such as the acquisition of facilities by chain providers, spending on construction, and overall volume of borrowing. For publicly owned providers, we can also monitor changes in share prices, debt, and other publicly reported financial information.

Payments and costs for 2006

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 2006 to inform our update recommendations for 2007.

For providers that submit cost reports to CMS—acute care hospitals, skilled nursing facilities, home health agencies, outpatient dialysis facilities, inpatient rehabilitation facilities, and long-term care hospitals—we estimate total Medicare-allowable costs and assess the relationship between Medicare's payments and those costs. The relationship between payments and costs is typically expressed as a payment margin. A margin is calculated as payments less costs divided by payments. (Alternatively, the relationship also can be expressed as a ratio of payments to costs.)

To estimate payments, we first apply the annual payment updates specified in law for 2005 and 2006 to our 2004 or 2003 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 the policy year (2007). 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 2006 would be if 2007 payment rules were in effect.

To estimate 2006 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 (that is, changes within the service provided—for example, 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 (for example, skilled nursing facility 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 that the facility furnishes. For example, a hospital might furnish inpatient, outpatient, SNF, home health, psychiatric, and rehabilitation services, each of which is paid under a different Medicare payment system. We would compute an overall hospital margin encompassing Medicare-allowed costs and payments for all of the sectors.

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

We calculate a sector's aggregate Medicare margin to inform our judgment about whether total Medicare payments cover efficient providers' costs. To assess whether changes are needed in the distribution of payments, we calculate Medicare margins for subgroups of providers that are important in Medicare's payment policies. For example, because location and teaching status enter into the payment formula, we calculate Medicare

margins based on where hospitals are located (in urban or rural areas) and by their teaching status (major teaching, other teaching, or nonteaching).

Multiple factors can contribute to a gap 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 (such as reduced lengths of stay at inpatient hospitals). Developing information about the extent to which these factors have contributed to the gap may help in deciding whether and how much to change payments.

Finally, the Commission makes a judgment when assessing the adequacy of payments relative to costs—the margin. No single standard governs this relationship. It varies from sector to sector and depends on the degree of financial risk faced by individual providers, which can change over time.

Appropriateness of current costs

Our assessment of providers' costs and the relationship between Medicare's payments and providers' costs is influenced by whether current costs approximate what efficient providers would be expected to spend in furnishing high-quality care to beneficiaries. 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—the product—changed significantly after the introduction of the home health prospective payment system. In other systems, coding may change. Any kind of rapid change can make measuring costs per unit of product difficult.

To assess whether reported costs provide a reasonable representation of the costs of efficient providers, we examine recent trends in the average cost per unit of output, variation in cost growth, and evidence of change in the product being furnished. Other things being equal, including the product being delivered, we would 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' need to be efficient in delivering services. In a sector where Medicare is not dominant, if other payers do not promote discipline, providers may have higher cost growth than they would have if Medicare were dominant. This phenomenon would be more common in markets where a few providers dominate and have negotiating leverage over the payers. For example, economic literature on the hospital industry and our analysis suggest that providers that are under fiscal pressure generally have managed to slow their cost growth more than those facing less fiscal pressure (Gaskin and Hadley 1997, MedPAC 2005).

Variation in cost growth among providers in a sector can give us insight into the range of performance that facilities are capable of achieving. For example, if some providers have more rapid cost growth than others, we might question whether those increases were appropriate.

Changes in product can significantly affect unit costs. Returning to the example of home health, substantial reductions in the number of visits in home health episodes would be expected to reduce the growth in per episode costs. If costs per episode instead increased at the same time as the number of visits decreased, one would question the appropriateness of the cost growth.

Accurate reporting is important for determining costs. When data are obtained from unaudited cost reports, costs could be understated or overstated. In some instances, some portion of costs has been found to be unallowable after CMS contractors audited facilities' cost reports.

In principle, we would like audits of all sectors' cost reports to ensure the accuracy of the reporting. For most providers, the current audit process reveals little about the accuracy of the Medicare cost information. The frequency of audits varies by sector. When audits are done, they generally focus on a narrow set of cost components that directly affect payment instead of broadly examining the accuracy of costs included in the reports. The Commission is studying possible steps to improve the auditing process.

What cost changes are expected in 2007?

The second part of the Commission's approach to developing payment update recommendations is to account for expected cost changes in the next payment year. For each sector, we review evidence about the factors that are expected to affect providers' costs. One major factor is changes in input prices, as measured by

the applicable CMS price index. For most providers, we use the forecasted increase in an industry-specific index of national input prices, called a market basket index. For physician services, we use a similar index—the Medicare Economic Index. 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.

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. For medical advances that both improve quality and increase costs, the Commission can include an allowance in our update recommendation. When reaching this judgment, the Commission takes into account the design of the payment system and how Medicare pays for new technology. For example, each year new monies are provided for new technologies used in both hospital inpatient and outpatient care; thus an additional allowance in update recommendations is not needed.

- ***Improvements in productivity***—Medicare's payment systems should encourage providers to reduce the quantity of inputs required to produce a unit of service by at least a modest amount each year while maintaining service quality. Consequently, the Commission has adopted a policy goal to create incentives for efficiency and includes an adjustment for productivity when accounting for providers' cost changes in the coming year. The Commission's productivity factor—0.9 percent for our 2007 deliberations—is a 10-year average of the Bureau of Labor Statistics' estimate of economy-wide, multifactor productivity growth. Our approach links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare. Market competition constantly demands improved productivity and reduced costs from other firms; as a prudent purchaser, Medicare should also require some productivity gains each year. Unless evidence suggests that this goal is unattainable systematically across a sector for reasons outside the industry's control, Medicare should expect improvements in productivity consistent with the average realized by the firms and workers who fund the Medicare program.

How should Medicare payments change in 2007?

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 concerning the distribution of payments among providers. These distributional changes are sometimes, but not always, budget neutral.

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. ■

References

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