

CHAPTER

1

**Evaluating Medicare's
payment policies**

Evaluating Medicare's payment policies

The Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 launched profound changes in Medicare's payment policies for many services furnished to beneficiaries under the traditional fee-for-service program and for health care organizations participating in the new Medicare+Choice program. These policy changes have raised important questions about the appropriateness of new payment systems' designs, their impact on beneficiaries' access to high-quality care, and their effects on providers' and health care organizations' financial incentives and performance. Policymakers and analysts have been frustrated, however, by the lack of unambiguous indicators that might suggest answers to these questions. In this chapter, the Medicare Payment Advisory Commission describes its approach to evaluating payment system performance. Although we concentrate primarily on payment systems in the traditional program, the same issues arise in evaluating payment policies in the Medicare+Choice program. The discussion focuses on three issues: what problems could result from limitations in the design or implementation of new payment policies, what indicators might suggest whether potential undesired outcomes are occurring, and what might be done to improve the availability of tools and information for detecting problems when new policies are adopted.

In this chapter

- Medicare's payment policy objectives and potential problems
 - MedPAC's approach to evaluating payment systems' design and performance
 - Improving tools and data
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The Balanced Budget Act of 1997 (BBA) and the Balanced Budget Refinement Act of 1999 (BBRA) required the Health Care Financing Administration (HCFA) to replace cost-based payment methods with new prospective payment systems (PPSs) for many types of providers participating in Medicare’s traditional fee-for-service program.¹ HCFA responded to these mandates, adopting new payment systems for services furnished by skilled nursing facilities (SNFs), hospital outpatient departments (OPDs), and home health agencies. In addition, the agency modified its payment systems for hospital inpatient care and physician services while developing new PPSs for inpatient rehabilitation facilities, long-term hospitals, psychiatric facilities, and ambulatory surgical centers.² Finally, HCFA also changed the method for determining prospective capitation payments for health care organizations that enroll beneficiaries in the Medicare+Choice program.

Under the law, the Medicare Payment Advisory Commission (MedPAC) must evaluate the design and implementation of these payment systems and make recommendations to the Congress and the Secretary of Health and Human Services to address any problems identified. In addition, we make annual payment update recommendations to the Congress for Medicare’s payment systems (see Chapter 2).

In carrying out these responsibilities, we have often faced difficult challenges in untangling the effects of Medicare’s payment policies from those of other factors that influence beneficiaries, providers, and health care organizations. The recent major payment reforms in a multitude of settings have greatly heightened the need for timely analysis of policy outcomes and exposed glaring

weaknesses in available evaluation measures. Consequently, we believe that substantial new efforts are needed in three areas. First, more resources should be devoted to developing focused measures of payment system performance that can more effectively meet policymakers’ ongoing needs for payment policy assessment. Second, before new payment systems are implemented, policymakers should direct more resources to preparing surveys and other targeted data collection efforts needed to detect potential problems before they have widespread effects on beneficiaries’ access to services or the quality of care they receive. Finally, new analytic tools are needed to monitor care patterns among beneficiaries.

In this chapter, MedPAC explores these problems and approaches that might be used to address payment policy evaluation questions and obtain relevant information to answer them. We begin by describing Medicare’s payment policy objectives and the kinds of payment problems that might arise. This is followed by a discussion of the approach and indicators we use in evaluating the design and performance of prospective payment systems. In the last section, we consider improvements in tools and information that might enable timely detection of emerging problems and overall assessments of payment policy performance. We also highlight several lessons that policymakers should draw from recent experience.

Medicare’s payment policy objectives and potential problems

Like other public and private health care purchasers, Medicare uses separate payment systems to compensate each type of provider—health care professionals,

Medicare’s principal goal—to ensure beneficiaries’ access to high-quality care in the most appropriate clinical setting, without imposing unwarranted financial burdens on beneficiaries or taxpayers.

Medicare’s payment policy objective—to set payment rates for products and services that are consistent with efficient providers’ short-run marginal costs in each local market. ■

facilities, suppliers, and health care organizations—for covered services furnished to beneficiaries in hundreds of markets nationwide. All of these payment systems raise recurring questions about what could go wrong and how we might know whether, and to what extent, undesired outcomes were occurring. As discussed in previous MedPAC reports, any attempt to answer these questions should start with Medicare’s payment policy objectives, which derive directly from the program’s principal goals (MedPAC 1999b, MedPAC 2000b).

Medicare’s payment policy objectives

Medicare was enacted to improve access to care by reducing the financial burden faced by elderly (and later disabled) people in obtaining medically necessary acute care services. Accordingly, Medicare’s principal goal is to ensure that its beneficiaries have access to medically necessary acute care of high quality in the most appropriate clinical setting, without imposing undue financial burdens on beneficiaries and taxpayers.³

1 Under prospective payment, providers’ payments are based on predetermined rates and are unaffected by their incurred costs or posted charges. Examples of prospective payment systems include the one Medicare uses to pay acute care hospitals for inpatient care and the physician fee schedule.

2 HCFA also has adopted or proposed other changes in payment methods, such as those for services furnished by independent therapists, durable medical equipment, and ambulance services.

3 In enacting the Medicare+Choice program, the Congress established the objective of giving beneficiaries choices—where feasible at no additional cost to Medicare—among alternative health care delivery systems and benefit packages. Nevertheless, the same overall goal of ensuring access to appropriate high-quality care should apply.

Medicare buys health care products and services from providers who compete for resources in private markets. To ensure beneficiaries' access to high-quality care, Medicare's payment systems therefore must set payment rates for health care products and services that are:

- high enough to stimulate adequate numbers of providers to offer services to beneficiaries,
- sufficient to enable efficient providers to supply high-quality services, given the trade-offs between cost and quality that exist with current technology and local supply conditions for labor and capital, and
- low enough to avoid imposing unnecessary burdens on taxpayers and beneficiaries through the taxes and premiums they pay to finance program spending.

In principle, these conditions would be met if Medicare's payment systems established payment rates approximating the competitive prices that would prevail in the long run in local health care markets. This is not a practical guide, however, because no one knows what these long-run market prices would be. Moreover, substantial discrepancies between Medicare's payment rates and providers' short-run marginal costs may lead to under- or over-supplies of services, causing serious problems for beneficiaries or taxpayers. Medicare's payment systems therefore must set payment rates that are consistent with efficient providers' short-run marginal costs. This means that the payment rates must accurately reflect predictable cost variations among products and services and those associated with patient or beneficiary characteristics and local market factors that are beyond providers' (or plans') control.

Setting and maintaining accurate payment rates across many health care settings in hundreds of local markets is a tall order for several reasons:

- Providers' costs are difficult to determine. We have little or no information about costs for most types of health care professionals—physicians or independent therapists, for example. The available measures for facility providers, such as hospitals and nursing facilities, are based on accounting costs, which may differ from true economic (resource) costs. Available cost information for Medicare+Choice plans suffers from similar limitations.
- Most health care providers and plans produce multiple products, many operate across two or more settings—hospital inpatient and outpatient services, for instance—and virtually all serve many patients or beneficiaries covered by other payers, making it difficult to isolate costs associated with specific services furnished to Medicare beneficiaries.
- Adjusting payment rates to reflect the effects of local market conditions—differences in input prices, for example—requires knowledge of providers' production processes and cost components, and accurate data (that are often not readily available) for related market factors.
- Medical science and technology and local market conditions are continually evolving; thus, payment rates must be frequently updated to maintain consistency with changes in efficient providers' costs.

Given these limitations, it is difficult to identify efficient providers and practically impossible to measure their short-run

marginal costs. Further, if all payers set their payment rates equal to efficient providers' short-run marginal costs, some providers would face insolvency because they would be unable to cover their fixed costs.⁴ As a result, policymakers usually set the initial payment rates in Medicare's prospective payment systems based on providers' historical average or median costs per unit and then rely on the incentives for efficiency inherent in predetermined payment rates to encourage providers to control their costs.⁵

What might go wrong

As with market-determined prices, Medicare's prospective payment rates create incentives for efficiency by placing providers at risk. Providers whose costs exceed the predetermined payment rate will take a loss; those whose costs remain below the payment rate keep the gain. Providers thus have financial incentives to improve efficiency for the products and services included in the payment rate.

Improving efficiency, however, is not providers' only option (Table 1-1). Even when payment rates accurately reflect efficient costs, some providers may lower their risk of loss by reducing their costs or increasing their revenues in other ways: stinting on services or inputs, unbundling the product by shifting some services to another setting, using the gray areas of diagnosis or procedure coding to overstate the complexity of care and receive higher payments (upcoding), submitting false claims, or ceasing to participate in Medicare.⁶ Each of these practices has potential short-run and long-run costs for providers, such as loss of reputation, risk of malpractice claims, return of unwarranted payments, or loss of market share. These potential costs discourage providers from making inappropriate responses to payment incentives.

4 Providers' fixed costs include expenses that do not vary with changes in output volume, such as interest, depreciation, and insurance payments associated with buildings and equipment, expenses for utilities, and many administrative costs that must be incurred to produce any volume of services.

5 Alternatively, policymakers may set the initial level of payment rates to produce total spending equal to (or some fraction of) anticipated spending under the previous payment system. The Congress has used this approach for several payment systems, such as the physician fee schedule, the new system for hospital outpatient services, and the one for Medicare+Choice plans.

6 This is not meant to imply that most providers engage in these practices, only that fixed prices reward those who do. These potential rewards also suggest that payment policies alone—however well formulated—are unlikely to be sufficient to ensure appropriate access to high-quality care at affordable cost for all beneficiaries in all markets. Consequently, other tools are needed, such as access and quality standards and related monitoring activities.

**TABLE
1-1**

Payment rates relative to providers' costs, associated incentives, and risks for beneficiaries and taxpayers

Payment level and configuration	Financial incentives for provider	Access and quality risks for beneficiary	Financial risk for:	
			Beneficiaries	Taxpayers
Payment level				
Any level relative to providers' costs	Improve efficiency; stint on services or inputs; shift component services to another setting; upcode diagnoses or procedures; engage in risk selection	Patients with high expected costs may face access problems; others may not receive all appropriate services or have to get care in several settings	Shifting services may lead to unwarranted copayments and excessive premiums	Shifting services and upcoding may lead to increased spending and unnecessarily high taxes
Above costs	Enter market; produce too many units	May receive too many units, with unnecessary clinical risk	Increased volume may trigger unwarranted copayments and excessive premiums	Increased volume and spending may result in unnecessarily high taxes, threatening program viability
Below costs	Deny access; stint or shift component services to another setting; exit market	May get care in less appropriate setting, receive too little care, or may not receive services	Possible savings from reduced copayments and premiums	Possible savings from reduced spending
Payment distribution				
Rates too high for some products, but too low for others	Shift mix of products away from those with low payment rates	Some may receive too much care while others receive too little	Some may face unnecessary copayments	Uncertain
Rates too high for some markets and too low for others	Produce too many services in some markets and too few in others; entry in some markets and exit in others	Patients in some areas receive too much care while those in other areas receive too little	Copayments and premiums may be higher or lower than appropriate	Uncertain

Providers' personal and professional ethics also play an important role. Further, when payment rates are consistent with costs, providers face little pressure to engage in these practices. Financial pressure to adopt one or more of them increases, however, as payment rates fall below providers' marginal costs.

Substantial discrepancies between payment rates and providers' costs may create other problems for beneficiaries and taxpayers. Discrepancies can occur in several ways, with varying potential consequences. First, the payment rates for

all products or services may be set too high or too low. When payment rates are too high (above marginal costs), providers have incentives to furnish too many units of service, exposing patients to unnecessary health risks and creating unwarranted burdens for beneficiaries and taxpayers. Conversely, when payment rates fall short of the marginal costs of additional services, providers have incentives to limit patients' access to care or stint on the services and inputs used to produce care. Thus, rates that are below marginal costs might cause access or quality problems for beneficiaries.

Second, even when the payment rate for a product or service is consistent with providers' costs, their marginal costs for some individual patients may differ substantially from the payment. In this case, providers have incentives to engage in risk selection, seeking only the least costly patients and avoiding those who are expected to need unusually expensive care.

Finally, payment discrepancies can occur when the payment rates are distorted relative to providers' costs among products or across markets. For example,

when the payment rates are set too high for some products or services and too low for others, providers have incentives to shift the mix of services they produce toward relatively profitable services and away from unprofitable ones. Similarly, when payment rates are not appropriately adjusted to reflect local market conditions—differences in input prices or low service demand in sparsely populated areas, for example—providers in some markets may be overpaid or underpaid. As a result, Medicare’s payment rates may stimulate too much market entry and the production of too many services in some markets, and market exit and too few services in others.

Because Medicare sets payment rates separately for each provider and setting, inconsistencies across settings in the payment rates for similar services also may cause problems for beneficiaries. Payment inconsistencies might distort the behavior of providers or beneficiaries in determining the types and amounts of services consumed and the settings in which they are furnished. Inconsistent payment rates, for instance, might encourage some providers to shift certain services usually furnished in a hospital OPD to financially more attractive clinics or ambulatory surgical centers (ASC), thereby potentially increasing clinical risks for some patients or reducing quality of care.

MedPAC’s approach to evaluating payment systems’ design and performance

To assess payment system performance and the likelihood of payment discrepancies, we begin by examining each system’s design, focusing on whether its structural elements are likely to enable HCFA to set and maintain accurate payment rates. We also review a wide range of information on recent trends and patterns in service volume, Medicare spending, and providers’ costs and revenues (where available) for services furnished to beneficiaries.

In conducting these analyses, we are guided by the payment policy framework described in our March 1999 report to the Congress (MedPAC 1999b). That framework considers design options for major system components, problems that might arise from design or data limitations, and factors that may affect the likelihood of these problems. It also considers relationships between payment systems for complementary and substitute services.

Our policy framework suggests important questions that should be asked about any payment system:

- Is the product or service that Medicare is buying well defined and does HCFA have sufficient ability to monitor product attributes so that fixed-price contracting is desirable?
- If so, does the overall design—unit of payment, product or service classification system, and so forth—establish an appropriate basis for fixed-price contracting?
- Is the distribution of payments consistent with expected variation in efficient providers’ costs resulting from differences in product mix or market conditions beyond providers’ control?
- Is the current level of the payment rates consistent with the costs efficient providers (or health care organizations) would incur in furnishing covered services to beneficiaries?
- How are providers’ costs expected to change in the forthcoming year as a result of anticipated changes in legitimate factors, such as market input prices or the introduction of new technologies?
- What payment tools and data may need improvement and how might improvements be accomplished?
- Do the payment rates established for a setting—physicians’ offices, for example—create financial incentives for inappropriate shifts of services to

or from potential substitute settings—hospital outpatient departments or ambulatory surgical centers, for instance?

The answers to these questions suggest expectations about the kinds of payment discrepancies that may arise in a particular system and thus what specific problems might be observed. Anecdotal reports from providers, industry associations, and beneficiary groups also suggest hypotheses about potential problems that may be occurring. These expectations and hypotheses often can be tested by analyzing administrative data—such as claims or cost report information—or by collecting data for specific process and outcome indicators.

The questions of greatest importance at any time differ according to the age and status of the various payment systems. For mature, well-functioning payment systems—those for hospital inpatient care and physician services, for example—we generally focus on only a few questions each year, such as what the annual payment update should be or what changes may be needed to improve accuracy for a particular payment adjustment. All of the questions identified earlier are important, however, in assessing the likelihood of potential payment discrepancies in recently introduced payment systems or those currently under development.

Evaluating payment systems’ designs

To set accurate payment rates in each setting, HCFA must know what products and services it is buying and what it should cost efficient providers to furnish them. Given appropriate knowledge, tools, and data, HCFA can establish good contracts with providers in which both sides know what products are being purchased and the payment rates among products and markets are consistent with efficient providers’ costs. Under such contracts, providers face financial risk primarily from a failure to produce care efficiently and random cost variation among patients. Further, opportunities for undesirable provider responses to

payment incentives are limited because HCFA knows what products and services it is paying for and can monitor effectively whether beneficiaries receive them.

Limitations in knowledge, tools, or available data, however, may impair HCFA's ability to define the products it is buying or set payment rates consistent with efficient providers' costs, leaving substantial uncertainty for both sides. Poor contracts increase the chances that payment discrepancies will occur, exposing providers to additional financial risk. They also leave opportunities for providers to reduce or avoid potential losses—in ways that may be difficult to detect—without improving efficiency. Compared with good contracts, poor ones thus put beneficiaries and taxpayers at greater risk.

In evaluating the payment system design in any setting, we focus initially on whether HCFA has the appropriate knowledge, tools, and data to establish a good contract (text box). This analysis may identify limitations in available tools or data that compromise HCFA's ability to achieve high contract standards. In these instances, we consider options for strengthening current tools and data and—if current limitations are serious and not easily remedied—whether full prospective payment is the most appropriate policy for achieving Medicare's access and quality goals.

HCFA's ability to establish good contracts depends primarily on four factors:

- the strength of the product definitions and HCFA's monitoring capabilities,
- whether appropriate supporting rules are established to set product boundaries,
- the availability of data for establishing accurate relative values among products, and
- the extent to which the system's design and available data accurately account for other important factors

Prospective payment system design elements

Prospective payment systems typically encompass six major elements:

Product definitions are determined by the unit of payment and a matching product classification system:

- the unit of payment may be an individual service or a bundle of services, such as a day of inpatient care, an inpatient stay, an episode of care, or a specified period of time;
- the product classification system defines distinct services or products, consistent with the unit of payment, that are expected to require different amounts of providers' resources.

Relative values measure the expected relative costliness of a unit of the product in each product classification category, compared with the average cost per unit across all categories.

Adjustments to payment rates are applied to the base payment amount to compensate for the effects on providers' costs of market factors (local input price levels, for example), unusual provider circumstances, or special characteristics of services and beneficiaries.

The base payment amount (sometimes called the conversion factor) is the national amount that would be paid in the current year to a provider for a standard unit of product (with a relative value equal to 1.0) in a market with national average input-price levels, if no other adjustments applied.

Annual payment update is a factor applied to the base payment amount to raise or lower all payment rates in the forthcoming year. The update is intended to reflect changes in efficient providers' costs expected to result from anticipated changes in market factors—input prices or adoption of new technologies, for example—beyond providers' control.

Supporting systems and processes are the infrastructure necessary to operate and maintain all system components, such as processes for making coverage decisions about new technologies, updating product definitions, assigning patient encounters to product categories, and data systems and processes for calculating and updating base payment amounts, relative values, and payment adjustments.■

that may affect efficient providers' costs, but are beyond their control.

Many of these factors vary widely among Medicare's payment systems in the traditional program (Table 1-2). Consequently, HCFA's ability to establish good contracts ranges from relatively high in the hospital inpatient PPS and the payment system for physicians' services to relatively low in the payment systems for SNF care and home health services.

Factors affecting the strength of product definitions

The capacity to forge good contracts depends on the strength of the product definitions used to set Medicare's payment rates and HCFA's ability to monitor product attributes. The product definitions in each payment system reflect the unit of payment and a matching product classification system for the particular setting, which identifies distinct services, types of days or cases, or

**TABLE
1-2**

Payment unit and factors affecting HCFA's ability to establish a good contract for selected fee-for-service providers and settings

Provider and setting	Payment unit (and product classification system)	Scope of services included in bundle	Clinical consensus on bundle content	Strength of product classification system	Supporting rules on product boundaries	Availability of data for relative values	Knowledge of production process	Availability of data for factors that affect costs
Physician office Medical	Procedure (HCPCS)	Narrow	Moderate	Strong	Site differential; bundling (coding) edits	Limited	Strong	Moderate
Surgical	Procedure (HCPCS)	Moderate (episode)	High	Strong	Site differential; multi-surgery discount; edits	Limited	Strong	Moderate
Physician other facility Medical	Procedure (HCPCS)	Narrow	Moderate	Strong	Site differential; bundling (coding); edits	Limited	Strong	Moderate
Surgical	Procedure (HCPCS)	Moderate (episode)	High	Strong	Site differential, multi-surgery discount; edits	Limited	Strong	Moderate
Hospital outpatient department	Procedure (APC)	Narrow	Mixed/high	Strong	Outlier policy for services during a day	Moderate	Strong	Extensive
Ambulatory surgical center*	Procedure (APC)	Narrow	High	Strong	None	Mixed/moderate	Strong	Limited
Hospital inpatient acute facility	Stay (DRG)	Broad	Mixed/high	Strong	72-hour rule; transfer policy; outlier policy	Extensive	Strong	Extensive
Rehabilitation facility*	Stay (FIM-FRG)	Broad	High	Strong	Transfer policy; outlier policy	Extensive	Strong	Moderate
Long-term hospital#	Stay (not chosen)	Broad	Mixed/moderate	Uncertain	Uncertain	Uncertain	Moderate	Moderate
Skilled nursing facility	Inpatient day (RUG-III)	Moderate	Moderate	Weak	Services bundled within scope of SNF benefit	Limited	Moderate	Limited
Home health agency	60-day episode (HHRG)	Broad	Low	Uncertain	Therapy and supplies bundled; 5-visit minimum; outlier policy	Limited	Moderate	Limited

Note: * proposed design. # under development. HCPCS (HCFA Common Procedure Coding System); APC (ambulatory payment classification); DRG (diagnosis related group); FIM-FRG (Functional Independence Measure-Function Related Groups); RUG-III (third version of Resource Utilization Groups); HHRG (home health resource group).

beneficiaries that are expected to require different amounts of providers' resources. Other things being equal, larger payment

units give providers more opportunities to economize on the resources used in furnishing care, but also more

opportunities to benefit from stinting on care or avoiding relatively costly patients (selection). Policymakers' choices among

payment units, however, are often limited by the lack of corresponding product classification systems or ready capability to monitor product content. For example, Medicare generally does not pay for physicians' services based on episodes of care because it lacks an effective episode classification system.⁷

Good product definitions require a product classification system that accounts for a substantial proportion of the predictable variation in providers' costs among products and reliable information for assigning services, cases, or beneficiaries to the product categories. Most product classification systems are based on clinical factors, such as diagnoses or procedures, that are expected to affect the content and duration of care. Good definitions thus generally reflect at least a moderate level of consensus among clinicians about the appropriate content and standards of care for the service or bundle of services included in each product.

The product classification systems used in Medicare's payment systems for hospital inpatient acute care and ambulatory care meet these criteria reasonably well. These classification systems include the diagnosis related groups (DRGs) for hospital inpatient care and the service classification systems, based on the HCFA Common Procedure Coding System (HCPCS), for physician services and ambulatory payment classification groups (APC) for hospital outpatient care. The classification system proposed for use in the payment system for rehabilitation facilities—functional independence measure-function related groups—also appears effective (Carter et al. 2000).⁸

In contrast, the classification systems used to pay for SNF care and home health services do not meet these criteria (see Chapter 6). Their ineffectiveness stems in large part from the lack of firm boundaries between acute care, which Medicare covers, and long-term care, which is not

covered. A major problem in classifying SNF care is that a substantial proportion of SNF patients go on to use uncovered long-term nursing home care, often in the same facility. In addition, although the Resource Utilization Groups (RUG) classification system is largely based on patients' needs for specific services, it does not adequately distinguish medically complex patients who require costly drugs, intravenous therapies, and supplies (Kramer et al. 2000). For home health care, the problem is a lack of clinical consensus about the appropriate mix and quantity of visits that should be furnished to patients with different problems during a 60-day episode of care. This problem may be especially difficult to resolve for the many home health episodes that are initiated without a prior acute hospital inpatient stay.

Good product definitions also require classification variables that are reasonably objective, readily available, and easily verified. If these criteria were not met, providers would have incentives to increase their revenues by manipulating the classification variables so that services or patients were assigned to higher-paid product categories. Product definitions based on information that is subjective or difficult to obtain and verify are likely to be unreliable and burdensome for providers and HCFA.

Again, the information used to assign services or patients to product categories for ambulatory and hospital inpatient care appear to satisfy these criteria, while that used for SNF and home health care is fraught with problems. For example, services performed in the OPD are assigned to APC categories based on the HCPCS code corresponding to the service or procedure. The accuracy of the service codes reported on hospitals' OPD claims can be independently verified by examining patients' medical records. In contrast, the SNF and home health classification systems are based on information from patient assessment

instruments that are difficult and time-consuming to use and produce subjective patient data of doubtful reliability (OIG 2000, Moore et al. 2000, Goldberg et al. 1999). Moreover, the classification variables—assessment items—cannot be independently verified at a later date because they represent subjective judgments at an earlier time; an auditor could not reexamine the patient and the medical record would only show the subjective judgment the assessor reached.

Supporting rules defining product boundaries

Supporting rules that establish product boundaries help to strengthen product definitions by neutralizing providers' financial incentives to unbundle the product or engage in risk selection. As mentioned, providers facing predetermined payment rates have incentives to unbundle the product by billing separately for services that should be included in the payment unit or by shifting some of these services to another setting. In addition, when the product classification system fails to capture severity differences among patients, providers have incentives to avoid patients whose care is expected to cost substantially more than the payment rate and seek patients whose care is likely to result in below-average costs.

To counter these incentives, most payment systems include several types of rules. Bundling rules typically prohibit providers from billing separately for services included in the bundle or discount payment—wholly or in part—when included services are furnished in another setting. For example, hospitals cannot bill separately for related outpatient services—such as laboratory tests or imaging services—furnished within 72 hours prior to a hospital admission. Similarly, physicians' payments are reduced when services are furnished in a hospital outpatient department or other facility instead of the physician's office.

⁷ One exception is surgical episodes; pre- and post-operative office visits are bundled together with the surgical procedure and paid under a global surgical payment rate. Another is end-stage renal disease; Medicare pays for physician management of dialysis services on a monthly capitation basis.

⁸ In its proposed rule (HCFA 2000), HCFA changed the name of this classification system to case-mix groups (CMG).

Transfer policies reduce providers' payment rates to reflect the decline in costs that occurs when services that ordinarily would have been furnished during the latter part of a stay are shifted to another setting.⁹ Finally, outlier policies provide additional payments to providers when they encounter unusually costly patients, at least partially offsetting the marginal costs of furnishing additional services. If these policies are well designed, they limit the benefits providers can realize from actions that might cause unwarranted increases in program spending or diminish beneficiaries' access to care or the quality of care they receive.

Availability of data for setting and maintaining accurate relative values

To establish a good contract, HCFA also must have data for setting and maintaining relative values that accurately reflect the relative costliness of each product. Limitations in the available data are likely to result in errors in the relative values among products, leading to overpayments for some products and underpayments for others. The data HCFA uses to set product relative values for Medicare's payment systems are quite varied and always imperfect to some degree. Even the data used to set relative values for DRGs in the hospital inpatient PPS have important limitations. For example, the relative values are based on hospitals' billed charges, which give a distorted picture of relative costliness across DRGs because they reflect systematic differences among hospitals in the average mark-up of charges over costs and in the level of costs per case (MedPAC 2000b, MedPAC 2000a).

Data limitations are substantially more serious, however, in some other payment systems, such as those for SNF and home health services. In these systems, the relative values are based on estimates of staff time usage in furnishing care—days of SNF care, for example, for patients assigned to different RUGs. Although

differences in the mix and quantity of staff time may account for much of the variation in per diem costs among SNF patients, these data are unlikely to produce accurate relative values for all SNF products because other important cost components, such as drugs and supplies, follow a different pattern. Errors in the relative values for both SNF and home health care are likely to be especially large for product categories—and patients—that require substantial amounts of prescriptions drugs and biologicals.

Availability of data for other rate adjustments

Finally, to support good contracts, the payment system in each setting must account appropriately for the impact of other factors that are expected to affect efficient providers' costs but are beyond their control. Almost all of Medicare's payment systems include rate adjustments intended to compensate providers for predictable cost differences associated with variation in:

- local market conditions, such as input-price levels or demand for services related to population density,
- special characteristics of patients or services offered, such as the proportion of patients who have end-stage renal disease, or
- specialized activities, such as operating programs for training residents (physicians) or other health professionals or serving a disproportionate share of low-income patients.

When these adjustments are set incorrectly, they degrade the purchase contract, resulting in payment errors across markets, for specific products, or for specific providers, which may threaten beneficiaries' access to care or diminish the quality of care they receive.

HCFA's capacity to set accurate payment adjustments for each payment system depends on knowledge of providers' production methods in each setting and the availability of accurate data for the relevant adjustment factors. Thus, for each setting, HCFA must understand the major components of providers' costs, such as labor, supplies, and equipment, and what factors are likely to affect those components. In addition, HCFA must collect data on those factors and design rate adjustments to account for their effects.

For example, because health care delivery is generally labor intensive, differences in market wage rates for occupations typically employed in health care organizations often account for a substantial proportion of observed nationwide variation in providers' unit costs. Consequently, accurate input-price adjustments are essential in setting appropriate payment rates for providers in each market area. For most facility providers, the market input-price adjustment is made by applying a wage index—which measures the relative level of average hourly wages in each market, compared with the national average wage rate—to raise or lower a portion of the base payment amount. The adjusted portion differs across settings, reflecting differences in the proportions of providers' costs that HCFA believes are affected by market wage levels. The wage index used in most facility settings, however, is based on labor compensation data collected only from acute inpatient and outpatient units in PPS hospitals. This problem as well as limitations in data content and labor market definitions, raises questions about the accuracy of the input-price adjustments for all facility settings, especially non-hospital settings (see Chapter 4).

Other adjustments address a variety of factors, such as additional payments for hospitals that operate residency programs for training physicians, and for those that

⁹ In the hospital inpatient PPS, hospitals are paid based on a per diem rate—up to a maximum of the full per discharge payment rate for the DRG—when they transfer a patient to another PPS hospital after a stay that is two or more days shorter than the national average length of stay for the DRG. This policy also applies for patients in 10 DRGs who are discharged to a rehabilitation facility, long-term hospital, SNF, or to related home health care.

are the sole providers in their communities (MedPAC 1999a). Recently, policymakers also have expressed interest in potential payment adjustments for low-volume providers that furnish inpatient or outpatient care in rural areas. (We expect to publish findings from our research on this issue in our June 2001 report to the Congress.)

Although current knowledge of providers' production processes is substantial for all settings, the quantity and quality of data available for analyzing factors that affect unit costs vary widely. HCFA has extensive claims and cost report data for hospitals, but available data for most other facility providers are limited, often of poor quality, and frequently lack information needed to assess existing or potential rate adjustments.

Is full prospective payment appropriate?

When limitations in knowledge, tools, and data prevent HCFA from establishing good contracts, substantial discrepancies may occur between the payment rates and efficient providers' short-run costs. In these instances, policymakers should be concerned that some providers might respond to the payment incentives in undesirable ways. The likelihood that some providers would respond inappropriately depends in large part on the power of the contract and the presence or absence of mitigating factors in the organizational environment surrounding care delivery.

The power of the contract

Other things being equal, providers' financial risk under prospective payment reflects two factors: the power of the contract and the scope of the service bundles included in the payment rates. The power of the contract is determined by the extent to which the payment rates are fixed in advance and unaffected by providers' incurred costs (Laffont and Tirole 1993). Contract power is greatest

when payment rates are completely fixed. This places providers fully at risk for the difference between the payment rate and their unit costs, maximizing their potential rewards and motivation for reducing their costs because they get to keep every dollar they save.

The extent to which payment rates are fixed differs somewhat among Medicare's prospective payment systems, reflecting variations in two types of policies. First, payment rates are not completely fixed when some cost components are carved out or excluded from the payment rate and paid separately. For instance, Medicare's per diem payment rates for SNF care exclude the cost of services that must be provided in another facility, such as emergency room visits, certain nonroutine diagnostic tests, or dialysis treatments. Costs for new drugs and devices are treated similarly for a three-year period in the OPD payment system when they would substantially increase hospitals' costs per unit in an outpatient procedure category (see Chapter 3). Such carve-outs—often called pass-throughs—are narrowly defined, however, and used in only a few payment systems.

The extent to which the payment rates are fixed also is reduced by outlier policies, which make extra payments to providers when they incur extraordinarily high costs in furnishing a patient's care (McClellan 1997). Outlier policies are intended to preserve beneficiaries' access to care by mitigating providers' financial incentives to avoid patients who are likely to be unusually costly. These policies generally are not needed in Medicare's payment systems for ambulatory care because providers are paid for each service they furnish.¹⁰ Medicare's payment systems for acute inpatient and post-acute care, however, are based on larger payment units—such as days, stays, or episodes—that encompass broader bundles of services. Except for the SNF payment system, all of these systems include an

outlier policy that triggers additional payments when providers' costs for individual patients exceed a threshold amount equal to the regular payment rate plus a fixed loss amount. The outlier threshold in the hospital inpatient PPS in fiscal year 2001, for example, is set at the regular payment rate for the DRG plus \$17,550. Medicare pays 80 percent of the provider's case-specific costs above the threshold.¹¹

Providers' financial risk also reflects the scope of the service bundles included in the payment rates, which varies widely among Medicare's payment systems. Financial risk is lower in payment systems with narrow payment units, compared with those based on broader payment units. For example, risk is relatively low in the payment systems for physicians' services or OPD care because providers can increase payments by furnishing more services. In contrast, risk is relatively high in the payment system for hospital inpatient acute care (and even higher in Medicare+Choice contracts) because furnishing more services increases providers' costs, but not payments; conversely providers who reduce services within a hospital stay keep all of the cost savings.

Potential mitigating factors in the organization of care delivery

Although the hospital inpatient PPS and the physician fee schedule represent good contracts, providers still have opportunities to respond to payment incentives in undesirable ways. Other payment systems, such as those for SNF care and home health services, present greater opportunities for payment discrepancies and undesirable provider responses. Providers' actual responses to payment incentives in each setting, however, depend on several factors, including:

- whether the care decisionmaker is also the service provider,

10 Policymakers made an exception in the OPD payment system; the outlier policy offsets facilities' higher costs when a patient receives an unusually large number of services in a single day.

11 McClellan argues that Medicare's prospective payment contracts with hospitals are not as high powered as they may at first seem, citing extra payments for outlier cases and higher payment rates when surgical or other procedures are performed.

- the extent of physician involvement in furnishing care, and
- the likelihood of clinical oversight.

These factors vary among care settings, potentially affecting the likelihood that providers might choose undesirable responses to payment discrepancies (Table 1-3). In some settings, the care decisionmaker differs from the service provider, and the financial incentives they face under separate payment systems are usually not aligned. In the hospital inpatient setting (and to a lesser degree in OPDs or ASCs) for example, the care decisionmaker is the patient’s physician who generally is independent and paid

separately from the hospital (or other facility service provider). In these instances, the potential for adverse responses to service providers’ payment incentives may be limited by physicians’ direct involvement in monitoring the care furnished by the facility staff. The chances of undesirable responses by the service provider are probably also reduced when oversight by other clinicians is routine.

In other settings, however, care decisionmakers and service providers may not be independent, physicians may have little direct involvement in the care beneficiaries receive, and clinical oversight may be limited. In these settings—skilled nursing facilities and

home health agencies, for example—only the organization’s culture and caregivers’ personal and professional ethics may inhibit undesirable responses to payment incentives.

Policy options when the contract is poor

The most obvious solution for a poor contract in a particular payment system is to pinpoint the weakness—usually the product classification system, its supporting data, or lack of data for setting relative values and appropriate payment adjustments—and strengthen the faulty tools and information. Building new classification systems or upgrading supporting data, however, usually involves a substantial effort that may take several years to bear fruit. What can be done in the short run until new tools and data are available?

We must find ways to limit the effects of potential payment discrepancies when the products being purchased are not well defined or other barriers prevent HCFA from setting accurate relative payment rates. In the past, policymakers have adopted several strategies to reduce financial risk for providers, lowering the likelihood that they would respond to payment problems in undesirable ways. One strategy is to accept the weaknesses of available tools and data in making initial design decisions about new prospective payment systems. Policymakers, for instance, might select a narrower payment unit with stronger product definitions rather than a broader unit that would be more consistent with clinicians’ thinking about episodes of care. The payment system for physicians’ services is an example. Some might argue that HCFA also followed this strategy in adopting narrower APC definitions with more limited bundling of procedure-related services than those it originally proposed. Similarly, using the day rather than the stay as the payment unit for SNF services might be viewed as one way of avoiding undesirable incentives and limiting financial risk for providers.

TABLE 1-3

Factors that may inhibit undesirable responses to payment discrepancies for selected fee-for-service providers and settings

Provider and setting	Care decisionmaker differs from service provider	Alignment of financial incentives for care decisionmaker and service provider	Extent of physician direction of care	Extent of clinical oversight
Physician office	No	Aligned	Strong	Limited
Hospital outpatient department	Yes	Generally not aligned	Strong	Moderate
Ambulatory surgical center*	Yes	Depends on whether physician is an owner	Strong	Moderate
Hospital inpatient	Yes	Generally not aligned	Strong	High
Rehabilitation facility*	No	Depends on physician compensation	Strong	High
Long-term hospital#	No	Depends on physician compensation	Strong	High
Skilled nursing facility	No	Generally aligned	Weak	Limited
Home health agency	No	Generally aligned	Weak	Limited

Note: * proposed design. # under development.

Another strategy is to continue to pay for some product components on the basis of incurred costs, thereby limiting the proportion of providers' costs at risk under prospective payment. Policymakers initially followed this strategy—with pass-through provisions for capital and direct medical education costs and those related to organ acquisition for transplants—in implementing the hospital inpatient PPS.

A third strategy is to implement a blended payment system in which a portion of providers' payments are based on prospective rates and the remaining portion on providers' incurred costs or fee schedules based on narrow service definitions. Policymakers employed a form of this strategy during the four-year transition to full prospective payment for operating costs per case under the hospital inpatient PPS. However, the cost-based portion of the payment was set equal to hospitals' case-mix adjusted operating costs per case in a base year updated for inflation, rather than actual incurred costs during each transition payment year. This reduced providers' financial risks relative to those they would have faced under the national prospective payment rates, but the reduction in risk was less than would have been achieved using providers' actual incurred costs. Using incurred costs, however, would have substantially weakened providers' incentives for efficiency (Newhouse 1996).

Evaluating the level of the payment rates and updates for the forthcoming year

As noted earlier, analysis of limitations in payment systems' designs and available data can suggest how the relative structure of payment rates among products and markets may differ from efficient providers' relative costs. We can use this information to identify the types of problems that may arise for providers and beneficiaries under a particular payment system. However, payment rates in any setting also may be set too high or too low across all products and markets.¹² Consequently, we also assess the current

level of the payment rates and the extent to which they may need updating for the forthcoming year to accommodate anticipated changes in factors—such as input prices, care technologies, or clinical practice patterns—that might be expected to affect providers' costs (see Chapter 2).

To assess the level of the payment rates, we review information on trends and patterns in a number of factors that might be related to Medicare's payment levels including:

- volume of services,
- providers' costs, revenues, and margins,
- product content,
- provider entry and exit, and
- beneficiaries' access to and quality of care.

Volume of services

Rapid growth in product volume furnished to beneficiaries could suggest that Medicare's payment rates are too high. Declines in volume could indicate the opposite. In practice, however, it is difficult to distinguish the effects of payment policies from those associated with changes in technology, beneficiaries' preferences, or diffusion of new care standards.

Providers' costs, revenues, and margins

Cost and financial data can be obtained for some types of providers from HCFA administrative files or industry surveys. These data can be used to track trends in providers' unit costs and financial margins for services furnished to beneficiaries and those furnished to all payers. Declines in unit costs that occur while input prices are rising may suggest that providers are improving efficiency. Alternatively, providers may be stinting on services or inputs. Similarly, if unit costs are rising at about the same rate as input prices, but providers' margins for Medicare services

are rising, then Medicare's payment rates may be too high. Correctly interpreting these trends is challenging, however.

Available information is often incomplete—we usually lack accurate measures of providers' overall product mix, for example. We lack the ability to control for changes in care quality. Finally, the information we have is based on accounting costs, which may differ substantially from true economic costs because allocations of fixed and overhead costs are arbitrary and because unit costs measure average rather than marginal costs.

Product content

Medicare administrative data and industry surveys also may suggest changes in the nature of providers' products—declines in length of hospital inpatient stays, for example. Some changes in product content reflect changes in technology, such as improvements in surgical techniques, drugs, and anesthesia. They also may result, however, from shifting services to other settings, which would reduce providers' costs without changing Medicare's payment rates. MedPAC has previously recommended reducing Medicare's hospital inpatient payment rates to offset the effects of shifting services to post-acute care settings (see Chapter 2).

Provider entry and exit

Rapid growth in the number of participating providers across many markets may indicate that Medicare's payment rates are too high. Conversely, widespread provider withdrawals from Medicare could suggest that the rates are too low.

Beneficiaries' access and quality of care

Evidence of widespread access or quality problems for beneficiaries may indicate that Medicare's payment rates are too low. In the absence of such evidence, the payment rates could be either about right or too high. Access and quality measures

¹² The level of the payment rates in any setting is determined by the base payment amount or conversion factor.

are often difficult to interpret, however, because they are influenced by many factors. Access to care for specific services, for example, may be influenced by beneficiaries' income, secondary (medigap) insurance coverage, preferences, or transportation barriers, which are all unrelated to Medicare's payment policies.

All of these measures present formidable challenges of interpretation. Consequently, none of them provides conclusive evidence about the appropriateness of Medicare's base payment amounts in any setting. Moreover, the availability, timeliness, and quality of information vary among settings. Nevertheless, the combined weight of evidence is sufficient to make reasonable judgments about payment levels for some settings, such as hospital inpatient care, physicians' services, and perhaps some other ambulatory care settings. Judgments about payment levels in post-acute care settings are subject to much greater uncertainty because little information is available about the appropriate volume of care or for the indicators identified earlier.

Improving tools and data

Analyzing the limitations of payment system design and available data in each setting can help identify which payment systems are likely to produce substantial payment discrepancies and the types of discrepancies. The findings from such an analysis within and across Medicare's payment systems should be used for several purposes. First, they highlight important weaknesses of payment system design and performance that could be remedied by improving or replacing specific payment tools and data. Second, they can be used to infer the specific types of problems that providers' responses to payment discrepancies might create for beneficiaries and taxpayers. This can help identify kinds of indicators and appropriate data sources for monitoring

payment systems' effects on providers and beneficiaries. Finally, the findings may suggest some important lessons for policymakers about problems that should be anticipated and addressed in developing and applying changes in Medicare's payment policies.

Strengthening tools and data to improve payment system performance

Although payment discrepancies may result from weaknesses in any payment system component, our analysis suggests that four components are especially important:

- the product classification system and supporting data,
- the accuracy of the relative weights,
- the accuracy of input-price adjustments, and
- the level of the base payment amount or conversion factor.

In some of Medicare's payment systems—those for post-acute care services, for example—major improvements are needed in at least the first two components.

Improving post-acute care classification systems is likely to require developing a better understanding of key clinical factors—such as the nature and mix of diseases and conditions, stage of disease progression, and functional status—and other factors (care objectives, availability of support at home) that should affect the mix and quantity of services furnished to patients. In addition, these factors must be captured for each patient in a reliable reporting system, either as part of providers' claims or linked to them. The most difficult challenge will be to distinguish patients' acute recovery and rehabilitation needs from their needs for long-term support services.

Rethinking post-acute care classification systems might yield three benefits. It

would focus attention on what we need to know about patients who are candidates for post-acute care. This might permit HCFA to simplify patient assessment and reporting systems, improving reliability and reducing the administrative burden on providers. Developing new classification systems also should enable clinicians to specify corresponding clinically based standards for care, which are essential for quality monitoring and for detecting some payment problems. Finally, standards of care associated with each product category imply types of resources needed to furnish appropriate care, which might help policymakers develop better methods for establishing and maintaining accurate relative values.

To enhance the accuracy of the relative values, policymakers will have to devote resources to improving the reliability of claims and cost report information submitted by providers. This might entail requiring providers to improve their systems for setting and posting service charges for non-routine services and those for allocating and reporting costs associated with categories of services furnished to beneficiaries.

Identifying problem and performance indicators and appropriate data sources

More effort is needed to develop timely and focused measures of payment systems' effects on providers and beneficiaries. Because resources are limited, however, this effort must be carefully targeted to the settings where problems are most likely to occur and the types of problems most harmful to beneficiaries. As noted earlier, analysis of payment system and data limitations suggests the kinds of payment discrepancies that may be likely in each setting and thus the potential provider responses we might expect to observe. Those expectations can then be used to infer the problems beneficiaries might experience, helping develop targeted indicators for monitoring payment systems' effects.

A number of useful indicators for evaluating payment systems' effects on providers could be developed by making better use of HCFA's administrative data. For some facility settings, this would require improvements in the content and quality of financial data providers report on their annual cost reports. Specific indicators might be similar to those we now use in analyzing payment policies' effects on hospitals under the inpatient PPS, including shifts or changes in patterns for:

- product volume
- product mix
- unit cost
- product content
- staff ratios
- revenues and margins for Medicare services
- provider participation

Problems of interpretation will remain, however, because providers' decisions about product volume and mix, staffing, and so forth are influenced by many factors—such as private payers' payment policies and local market conditions—other than Medicare's payment rates.

Indicators of payment systems' effects on beneficiaries' access to and quality of care are more difficult to develop and frequently require specialized surveys of beneficiaries or providers. Moreover, such associations are difficult to demonstrate. Nevertheless, substantial efforts are needed in HCFA and elsewhere to advance the policy community's ability to measure and monitor changes in access to and quality of care. Observed trends in access or quality may not be attributable to changes in payment policies. Still, a variety of sensitive indicators can highlight non-payment problems that need attention and they are necessary for assessing the extent to which Medicare is meeting its overall goal of ensuring access to high-quality care.

Lessons for policymakers

Our assessment of Medicare's payment systems in the traditional program also holds some lessons for policymakers. One is that HCFA cannot do everything at once. The BBA required many changes in Medicare's payment policies within a very short period. Developing and implementing new payment systems is a difficult and time-consuming task in the best of circumstances; adopting five or six new systems nearly simultaneously is unprecedented.

Given the volume of work, HCFA lacked the staff resources and time to fully prepare new payment systems and make the necessary changes in its administrative systems. Some objectives that could have been addressed in less hectic conditions were sacrificed, including prior development of monitoring systems to track changes in provider behavior that might adversely affect beneficiaries.

Other tasks—such as delivery of critical coding, patient assessment, and billing software to HCFA's fiscal agents and providers for pre-testing, and the development and dissemination of edit standards—were often delayed until new payment systems were about to go into effect. As a result, fiscal agents and providers had little time to prepare their internal data systems to process claims under the new systems. Further, because changes in provider reporting requirements were not implemented in advance, baseline data needed to measure and evaluate changes in the volume and mix of services under the new systems are often unavailable. This problem is especially serious for SNF and home health care, in which patient assessment instruments needed to assign patients to new payment categories were not widely used prior to the adoption of prospective payment.

These problems contrast sharply with what occurred when HCFA adopted new payment systems for hospital inpatient care and physician services. Before implementing the hospital inpatient PPS in 1983, HCFA developed a monthly

monitoring system that tracked changes in discharge volume, length of stay, and other indicators that might suggest whether providers were responding to the new payment system as policymakers intended. In addition, hospitals were using the clinical coding systems needed to assign patients to DRGs for several years before the inpatient PPS was implemented. Similarly, before the physician fee schedule took effect in 1991, HCFA and the Physician Payment Review Commission (PPRC) developed monitoring systems and special surveys to track physicians' responses to the payment system. PPRC also developed physician and beneficiary surveys designed to detect changes in access to care.

Many of the problems caused by inadequate preparation have been (or will be) compounded by the continuing changes in payment policies mandated in recent legislation. The BBRA and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required an already overburdened HCFA to make changes in many of its payment systems under extremely tight deadlines. Although many of these policy revisions are arguably needed, they create substantial administrative problems for HCFA and providers and instability in Medicare's payment rates. The latter outcome is clearly inconsistent with one of the objectives of prospective payment; setting payment rates in advance to reduce uncertainty and facilitate planning for providers and HCFA.

A second lesson is that we get what we pay for. Many of the data limitations that cause problems in establishing accurate payments for some settings are due, at least in part, to chronic underfunding of HCFA's administrative budget. Activities that help to improve the accuracy and reliability of providers' reported data—such as auditing cost reports or developing and disseminating coding instructions—have received inadequate support for many years. HCFA's administrative expenses generally have accounted for less than 2 percent of total outlays in

recent years, well below the comparable proportion of private insurers' expenses for similar activities. Consequently, data necessary to develop critical payment system components, evaluate important policy options, or detect serious problems often have been lacking or unreliable.

The lack of adequate monitoring tools and data is a major problem, especially in a period of rapid change. This problem will be difficult and costly to remedy. Consequently, additional resources will be needed to develop better data for setting and maintaining accurate payment rates and to expand monitoring activities to satisfy policymakers' ongoing needs for payment policy assessment.

Finally, in some instances, the tools and data available in the short run may suffer from so many limitations that policymakers should carefully consider whether prospective payment is appropriate. The alternative policy is partial or complete reliance on cost reimbursement or a fee schedule based on a narrow payment unit, with limits on cost

increases, the extent to which services can be billed separately, and other potential restrictions. Compared with cost reimbursement, prospective payment gives providers strong incentives to reduce costs. But prospective payment is not always better. If the products Medicare is buying cannot be well defined and monitored, or payment rates are likely to be seriously inaccurate for other reasons that cannot be easily corrected, prospective payment might expose beneficiaries to substantial risk with little chance of benefit.

The corollary is that payment system designs and the supporting data should be carefully and fully evaluated based on empirical evidence in an open process before they are adopted. If the evidence shows that the best currently available design would still produce a poor contract, then policymakers should be willing to rethink the desirability of pursuing prior decisions to adopt prospective payment. (This possibility applies not only to the current payment systems for SNF care and

home health services, but to new systems under development for long-term hospitals and psychiatric facilities.) Sometimes the best we can do is not good enough, and we have to go back to the drawing board. That is not cause for shame or recriminations; rather, it is good public policy to avoid making potentially costly mistakes.

What to do with poor contracts that have been adopted is an open question. If total payments to providers are adequate and systematic payment distortions tend to offset for individual providers, policymakers may be willing to let the current payment system continue until a better replacement can be developed. Whether these conditions hold for SNF care and home health services, however, is impossible to judge based on currently available information. Consequently, decisions about short-run policy options for these settings will have to await further information about beneficiaries' and providers' experiences under these payment systems.

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