

CHAPTER

2

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

R E C O M M E N D A T I O N S

Section 2A: Hospital inpatient and outpatient services

2A-1 The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2010 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.

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

.....

2A-2 The Congress should reduce the indirect medical education adjustment in 2010 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the indirect medical education adjustment should be used to fund a quality incentive payment program.

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

Section 2B: Physician services and ambulatory surgical centers

2B-1 The Congress should update payments for physician services in 2010 by 1.1 percent.

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

.....

2B-2 The Congress should establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary-care-focused practitioners. Primary-care-focused practitioners are those whose specialty designation is defined as primary care and/or those whose pattern of claims meets a minimum threshold of furnishing primary care services. The Secretary would use rulemaking to establish criteria for determining a primary-care-focused practitioner.

COMMISSIONER VOTES: YES 13 • NO 2 • NOT VOTING 1 • ABSENT 1

.....

2B-3 The Congress should direct the Secretary to increase the equipment use standard for expensive imaging machines from 25 hours to 45 hours per week. This change should redistribute relative value units from expensive imaging to other physician services.

COMMISSIONER VOTES: YES 14 • NO 0 • NOT VOTING 2 • ABSENT 1

.....

2B-4 The Congress should increase payments for ambulatory surgical center (ASC) services in calendar year 2010 by 0.6 percent. In addition, the Congress should require ASCs to submit to the Secretary cost data and quality data that will allow for an effective evaluation of the adequacy of ASC payment rates.

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

Section 2C: Outpatient dialysis services

2C The Congress should maintain current law and update the composite rate in calendar year 2010 by 1 percent.

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

R E C O M M E N D A T I O N S

Section 2D: Skilled nursing facility services

- 2D** The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2010.

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

.....

Section 2E: Home health services

- 2E-1** The Congress should eliminate the market basket increase for 2010 and advance the planned reductions for coding adjustments in 2011 to 2010, so that payments in 2010 are reduced by 5.5 percent from 2009 levels.

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

.....

- 2E-2** The Congress should direct the Secretary to rebase rates for home health care services in 2011 to reflect the average cost of providing care.

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

.....

- 2E-3** The Congress should direct the Secretary to assess payment measures that protect the quality of care and ensure incentives for the efficient delivery of home health care. The study should include alternative payment strategies such as blended payments and risk corridors and outcome-based quality incentives.

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

.....

Section 2F: Inpatient rehabilitation facility services

- 2F** The update to the payment rates for inpatient rehabilitation facility services should be eliminated for fiscal year 2010.

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

.....

Section 2G: Long-term care hospital services

- 2G** The Secretary should update payment rates for long-term care hospitals for fiscal year 2010 by the projected rate of increase in the rehabilitation, psychiatric, and long-term care hospital market basket index less the Commission's adjustment for productivity growth.

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

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

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 (2009). Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2010). Finally, we make a judgment on 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 nine sectors: hospital inpatient, hospital outpatient, physician, ambulatory surgical center, skilled nursing facility, home health, outpatient dialysis, inpatient rehabilitation facilities, and long-term care hospitals. The analyses of payment adequacy by sector are in the sections that follow. ■

In this chapter

- Are Medicare payments adequate in 2009?
- What cost changes are expected in 2010?
- Limitations to payment adequacy analysis across post-acute care settings
- How should Medicare payments change in 2010?
- Further examination of payment adequacy

The goal of Medicare payment policy is to get good value for the program’s expenditures, which means maintaining beneficiaries’ access to high-quality services while encouraging efficient use of resources. Necessary steps toward achieving this goal involve:

- setting the base payment rate (i.e., the payment for services of average complexity) at the right level;
- developing payment adjustments that accurately reflect market, service, and patient cost differences beyond providers’ ability to control; and
- considering the need for annual payment updates and other policy changes.

Our general approach to developing payment policy recommendations attempts to do two things: first, make enough funding available to ensure that payments are adequate to cover the costs of efficient providers, and second, improve payment accuracy among services and providers. Together, these steps should maintain Medicare beneficiaries’ access to high-quality care while creating financial pressure on providers to make better use of taxpayers’ and beneficiaries’ resources.

To help determine the appropriate level of aggregate funding for a given payment system in 2010, we consider:

- Are payments adequate for efficient providers in 2009?
- How will efficient providers’ costs change in 2010?

Taking into account those two factors, we then determine how Medicare payments for the sector in aggregate should change in 2010. Efficient providers use fewer inputs to produce quality outputs. Efficiency could be increased by

using the same inputs to produce a higher quality output or by using fewer inputs to produce the same quality output. 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—2009. In the second part, we assess how we expect efficient providers’ costs to change in the policy year—2010. We are exploring ways to approximate the characteristics of efficient providers. For example, in past years, we examined the financial performance of hospitals with consistently low risk-adjusted costs per discharge (MedPAC 2008). This year, we extend those analyses by examining a set of hospitals with historically low risk-adjusted costs, mortality, and readmissions.

Within a given level of 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 2010. This analytic process is illustrated in Figure 2-1.

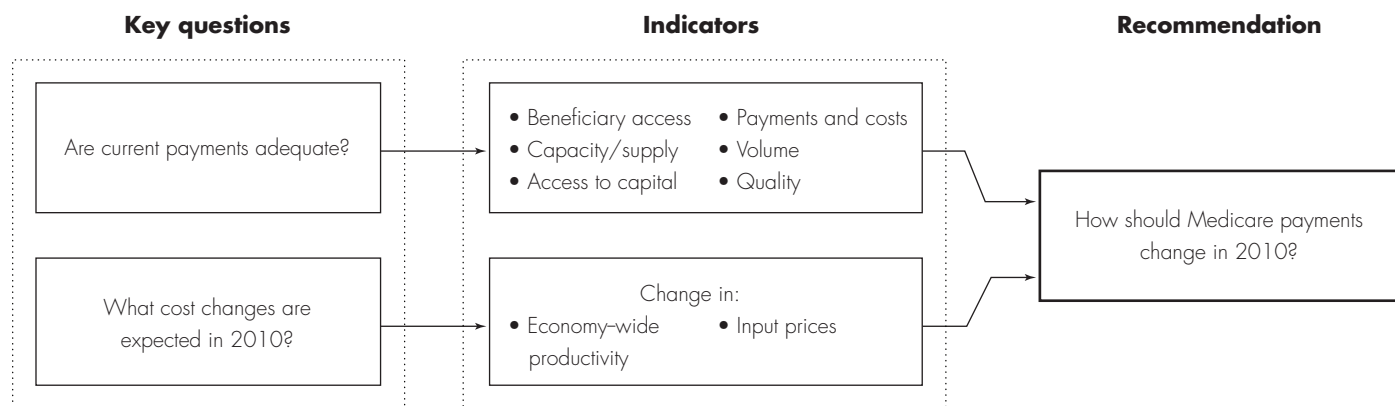
Are Medicare payments adequate in 2009?

The first part of the Commission’s approach to developing payment updates is to assess the adequacy of current Medicare payments. For each sector, we make a judgment by examining information on:

- beneficiaries’ access to care
- changes in the capacity and supply of providers

FIGURE 2-1

Payment adequacy framework



- changes in the volume of services
- changes in the quality of care
- providers' access to capital
- Medicare payments and providers' costs for 2009

Some measures focus on beneficiaries (e.g., access to care) and some focus on providers (e.g., the relationship between payments and costs in 2009). We consider multiple measures because the direct relevance, availability, and quality of each type of information vary among sectors, and no single 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, we examine data on whether communities are served by providers.

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 their costs. Changes in technology and practice patterns may also affect providers' capacity. For example, less invasive procedures or lower priced equipment could increase providers' 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 (HHAs) could suggest that Medicare's payment rates are at least adequate and potentially more than adequate. If Medicare is not the

dominant payer for a given provider type, 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. However, changes in the volume of services are often difficult to interpret because increases and decreases 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. For example, the number of Medicare beneficiaries in the traditional fee-for-service (FFS) program has decreased in some years as more beneficiaries choose plans in the Medicare Advantage program; therefore, we look at the volume of services per FFS beneficiary as well as the total volume of services. Explicit decisions about service coverage can also influence volume. For example, in 2004 CMS redefined arthritis conditions it thought appropriate for treatment in inpatient rehabilitation facilities (IRFs), a decision that contributed to a reduction in IRF volume. Changes in the volume of physician services must be interpreted particularly 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 any other sector depends on how discretionary the services are and on 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. Many factors influence quality, 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 (e.g., 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 2005 and 2004 reports (MedPAC 2005, MedPAC 2004). Specifically, the Commission recommended that pay-for-performance programs be implemented for hospitals, physicians, dialysis facilities and physicians furnishing services to dialysis patients, HHAs, and Medicare Advantage plans (MedPAC 2005, MedPAC 2004). For hospitals and dialysis providers, measures are already available for such a program. For physicians, we described a two-step process that starts with measures of information technology function and moves on to process of care and other measures. Last year, the Commission recommended that pay for performance be adopted for skilled nursing facilities (SNFs) (MedPAC 2008).

Providers' access to capital

Access to capital is necessary for providers to maintain and modernize their facilities and capabilities for patient care. Widespread inability to access capital 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, when providers derive most of their payments from other payers or other lines of business, or when conditions in the credit markets are extreme.

This year, because of the extraordinary conditions in the credit market, access to capital is being driven almost entirely by factors other than Medicare payment adequacy. For example, health care municipal bond issuances reached \$24.7 billion in the second quarter of 2008 (a level not seen since 1990); the market then essentially froze in late September and virtually no health care entities issued municipal bonds (*Modern Healthcare* 2008). The lack of access to capital in late September through most of October was not a result in changes in the adequacy of Medicare payments; it was a result of the conditions in the credit markets. Therefore, although we may reference

some of the usual determinants of access to capital, such as the underlying financial condition of providers, any projections about access to capital are guarded because of the extreme volatility in the credit markets. With conditions changing daily, any forecast about access to capital that is based on a snapshot of current data may be incorrect in a few months and will have little to do with the adequacy of Medicare payments.

A closely allied question is: How will overall economic conditions affect the health care sectors' financial performance? For example, the decline in investment portfolios, increasing interest expenses, and possible declines in private payer patient volumes and increases in uninsured patients may lower overall financial performance. But the adequacy of Medicare payments will not necessarily decline as a result. For example, if hospitals control their costs in reaction to economic conditions, we may see lower wage increases and lower supply costs—which might offset factors that increase unit cost, such as a decline in volumes. Attempting to offset overall economic conditions through increased Medicare payment updates would not be appropriate, because the implications of the decline in overall economic conditions for Medicare payment adequacy are not straightforward, may change in the short run, and may differ by sector.

Increasing updates would also be a poorly targeted response to economic problems. Base rate increases go to all providers, yet not all providers are equally affected by the economy or equally dependent on Medicare payments. For example, a hospital with few Medicare patients would be hurt more by a decline in employer insurance coverage caused by a declining economy than would a hospital with a high percentage of Medicare patients. Yet an increase in the update would help the second hospital more than the first. Moreover, addressing problems resulting from a poor economy by increasing Medicare payments would either further threaten program sustainability or require increasing taxes. In particular, the Medicare Part A Trust Fund is financed by a payroll tax, and any increase in the payroll tax may discourage employers from hiring or retaining workers—not the best signal to send a troubled economy.

Payments and costs for 2009

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 2009 to inform our update recommendations for 2010.

For providers that submit cost reports to CMS—acute care hospitals, SNFs, HHAs, outpatient dialysis facilities, IRFs, and long-term care hospitals (LTCHs)—we estimate total Medicare-allowable costs and assess the relationship between Medicare’s payments and those costs. We typically express the relationship between payments and costs as a payment margin, which is calculated as payments less costs divided by payments. By this measure, if costs increase faster than payments, margins will decrease.

To estimate payments, we first apply the annual payment updates specified in law for 2008 and 2009 to our 2007 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 2010. This method allows us to consider whether current payments would be adequate under all applicable provisions of current law. The result is an estimate of what payments in 2009 would be if 2010 payment rules were in effect. To estimate 2009 costs, we consider the rate of input price inflation and historical cost growth. As appropriate, we adjust for changes in the product (i.e., changes within the service provided, such as 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 (e.g., SNF or home health services). However, in the case of hospitals, which often provide services that are paid for in multiple Medicare payment systems, our measures of payments and costs for an individual sector may become distorted because of the allocation of overhead costs or cross subsidies among services. For hospitals, we assess the adequacy of payments for the whole range of Medicare services they furnish—inpatient, outpatient, SNF, home health, psychiatric, and rehabilitation services (each of which is paid under a different Medicare payment system). We compute an overall hospital margin encompassing Medicare-allowed costs and payments for all 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. The adequacy of Medicare payments is assessed relative

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 determine whether total Medicare payments cover average providers’ allowable costs and to inform our judgment about payment adequacy. To assess whether changes are needed in the distribution of payments, we calculate Medicare margins for certain subgroups of providers with unique roles in the health care system. 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 their teaching status (major teaching, other teaching, or nonteaching).

Multiple factors can contribute to changes in the Medicare margin, including changes in the efficiency of providers, unbundling of the services included in the payment unit, and other changes in the product (e.g., reduced lengths of stay at inpatient hospitals). Information about the extent to which these factors have contributed to margin changes may help in deciding how much to change payments.

Finally, the Commission makes a judgment when assessing the adequacy of payments relative to costs. No single standard governs this relationship for all sectors, and margins are not the only indicator for determining payment adequacy.

Appropriateness of current costs

A number of factors—including a provider’s response to changes in the payment system, provider efficiency, product changes, and cost-reporting accuracy—complicate our assessment of the relationship between Medicare’s payments and providers’ costs. Measuring the 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 types of visits in a home health episode changed significantly after the home health prospective payment system (PPS) was introduced. In other systems, coding may change. For example, the hospital inpatient PPS recently introduced a new patient classification system that eventually will result in more accurate payments. However, in the near term, it is predicted to result in higher payments because provider coding will improve, making patient complexity appear higher—although the underlying patient complexity is unchanged. Any kind of rapid change in policy,

technology, or product can make it difficult to measure costs per unit of comparable product.

To assess whether reported costs reflect the costs of efficient providers, we examine recent trends in the average cost per unit of output, variation in standardized costs and cost growth, and evidence of change in the product being furnished. One issue Medicare faces is the extent to which private payers are exerting pressure on providers to constrain cost. If private payers do not exert pressure, providers' costs will increase and, all other things being equal, margins on Medicare patients will decrease. Providers that are under pressure to constrain costs generally have managed to slow their growth in cost more than those facing less pressure (Gaskin and Hadley 1997, MedPAC 2005). Lack of cost pressure would be more common in markets where a few providers dominate and have negotiating leverage over payers. (See the text box in the hospital chapter, pp. 62–64, for a more complete discussion of the relation between cost pressure and Medicare margins.)

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 in a given sector have more rapid growth in cost than others, we might question whether those increases are 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 costs per episode. If costs per episode instead increased while the number of visits decreased, one would question the appropriateness of the cost growth.

What cost changes are expected in 2010?

The second part of the Commission's approach to developing payment update recommendations is to account for anticipated cost changes in the next payment year. For each sector, we review evidence about the factors that are expected to affect providers' costs. A major factor is change in input prices, as measured by the applicable CMS price index. For facility 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 CMS-derived weighted average of price changes for inputs used to provide

physician services. 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. Another factor is the trend in actual cost growth, which may be used to inform our estimate if it differs significantly from the market basket.

A final factor that figures into our estimate of cost change is improvement in productivity. Competitive markets demand continual improvements in productivity from workers and firms. These workers and firms pay the taxes used to finance Medicare. Medicare's payment systems should exert the same pressure on providers of health services. Consequently, the Commission may choose to apply an adjustment to the update to encourage providers to produce a unit of service as efficiently as possible while maintaining quality. The Commission begins its deliberations with the expectation that Medicare should benefit from productivity gains in the economy at large (the 10-year average of productivity gains in the general economy, currently 1.3 percent). But the Commission may alter that expectation depending on the circumstances of a given set of providers in a given year. This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay the taxes that fund Medicare.

Limitations to payment adequacy analysis across post-acute care settings

Medicare provides coverage for beneficiaries in four post-acute care (PAC) settings: SNFs, HHAs, IRFs, and LTCHs. Prospective payment systems for each setting were developed and implemented separately to control growth in spending and encourage more efficient provision of services in each setting.

While we assess the adequacy of payments under each of these PPSs, these separate systems encompass their own incentives (both positive and negative) that may distort the provision of PAC. The individual "silos" of PAC do not function as an integrated system—in which a common patient instrument assesses patient care needs and guides placement decisions, payments reflect the resource needs of the patients and not the setting, and outcomes gauge the value of the care furnished. Several barriers inhibit integration of the current systems and undermine the

program's ability to purchase high-quality care in the least costly PAC setting consistent with the care needs of the beneficiary. These barriers include:

- inaccurate case-mix measurement
- incomparable data on the quality and outcomes of care
- lack of evidence-based standards

The Deficit Reduction Act of 2005 (DRA) required CMS to conduct a demonstration that supports PAC payment reform across settings. CMS has begun data collection for the demonstration, using a common patient assessment instrument and gathering cost information at hospital discharge and at each PAC setting that beneficiaries use. The report on the demonstration is due July 2011. Thus, while CMS envisions an integrated system and has taken a key step toward developing one, implementation is years away.

The barriers that undermine the integration of care across PAC settings also limit our ability to assess differences in financial performance across providers in the same setting. Without an adequate case-mix adjuster, observed differences in costs could reflect differences in the mix of patients treated rather than efficiency. Differences in costs could also be attributable to variations in the quality of care furnished and the outcomes patients achieve.

Broad PAC reform that the Commission favors—and that the post-acute demonstration mandated by the DRA envisions—has begun but is several years away. In the meantime, PAC services will continue to be paid for under separate PPSs, and the program must continue to ensure that payments are adequate, while discouraging patient selection and encouraging providers to furnish high-quality services.

How should Medicare payments change in 2010?

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 about the distribution of payments among providers. These distributional changes are sometimes, but not always, budget neutral. Our recommendations for pay for performance are one

example of distributional changes that will affect providers differentially based on their performance.

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.

Further examination of payment adequacy

As discussed in Chapter 1, it is essential to look at payment adequacy not only within the context of individual payment systems but also in terms of Medicare as a whole. The Commission is alarmed by the trend in Medicare spending per beneficiary—a growth rate well above that of the economy overall—without a commensurate increase in value to the program, such as higher quality of care or improved health status. If unchecked, the growth in spending, combined with retirement of the baby boomers, will result in the Medicare program absorbing unprecedented shares of the gross domestic product and of federal spending. Slowing the increase in Medicare outlays is important; indeed, it is urgent. Medicare's rising costs, coupled with the projected growth in the number of beneficiaries, will significantly burden taxpayers.

The financial future of Medicare prompts us to look at payment policy and ask what can be done to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity.

In many past reports, the Commission has stated that Medicare should institute policies that improve the value of the program to beneficiaries and taxpayers. These policies should help improve the Medicare payment system. Policies such as pay for performance that link payments to the quality of care providers furnish should be implemented. To reduce unwarranted variation in volume and expenditures, Medicare should collect and distribute

information about how providers' practice styles and use of resources compare with those of their peers. Ultimately, this information could be used to adjust payments to providers. Increasing the value of the Medicare program to beneficiaries and taxpayers requires knowledge about the costs and health outcomes of services. Until more information on the comparative effectiveness of new and existing health care treatments and technologies is available, patients, providers, and the program will have difficulty determining what constitutes good-quality care and effective use of resources.

As we examine each of the payment systems, we also look for opportunities to develop policies that can create incentives for providing high-quality care efficiently across providers and over time. Some of the current payment systems create strong incentives for increasing volume, and very few of these systems encourage providers to work together toward common goals. Future Commission work will examine innovative policies for the FFS program.

Medicare should exert continued financial pressure on providers to control their costs, much as would happen in a competitive marketplace. We have found, for example, that hospitals under financial pressure from the private sector tend to control their costs and cost growth better than those with high non-Medicare profits (MedPAC 2008). In recent years, hospitals' non-Medicare profits have been high and so has hospital cost growth. Medicare payments have not fully accommodated this cost growth and hence Medicare margins have declined—and that has placed some pressure on hospitals to constrain costs. Through 2007, this pressure has not seemed to affect providers' investment in new capital or other expansion projects, which reached record levels. In 2008, as credit markets deteriorated, some projects started to be delayed and there is much uncertainty about future investment. Cost growth may be affected by the larger economic conditions as well, in either direction. Therefore, the Commission must remain vigilant in the face of this uncertainty, closely examining adequacy indicators for providers, making sure there is pressure to contain cost growth, and setting a demanding standard for determining which providers qualify for a payment update each year. ■

References

Gaskin, D., and J. Hadley. 1997. The impact of HMO penetration on the rate of hospital cost inflation, 1985–1993. *Inquiry* 34, no. 3 (Fall): 205–216.

Medicare Payment Advisory Commission. 2008. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2005. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2004. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Modern Healthcare. 2008. Financial meltdown hits home. September 29.