CHAPTER 1

A Framework for Considering Medicare Payment Policy Issues

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In this chapter

- Payment policy objectives and environment
- Major design decisions

Medicare's payment policies determine the amounts providers will be paid for covered services and supplies used by its beneficiaries. To ensure that beneficiaries have access to necessary care, these policies must work appropriately for thousands of distinct products and services furnished by a multitude of providers—health care professionals, facilities, suppliers, and health care organizations—in hundreds of market areas nationwide. To guide its analysis of payment issues in all of these settings, the Medicare Payment Advisory Commission has begun developing a payment policy framework. This chapter lays out the issues that must be addressed in designing or updating prospective payment systems and a framework for thinking about them. In the coming year we intend to refine this framework and identify explicitly a set of consistent principles that policymakers should follow when they make payment policy decisions.

Historically, Medicare has used a variety of methods to determine providers' payments, including retrospective reimbursement of allowable costs, allowed fees or charges, and prospective payment.[1] Today, payments for most services furnished by hospital outpatient facilities, home health agencies, inpatient rehabilitation facilities, long-term care hospitals, rural health clinics, and several other types of providers are still at least partially determined by the facility's incurred costs. Cost-based payment methods have long been criticized because they are complex, they result in unpredictable payments and spending for providers and Medicare, and they weaken providers' incentives for efficiency.

The Balanced Budget Act of 1997 (BBA) required the Health Care Financing Administration (HCFA) to replace cost-based methods with new prospective payment systems (PPSs) for many types of providers operating in the traditional fee-for-service program. New systems must be implemented for skilled nursing facilities (SNFs), hospital outpatient departments (OPDs), home health agencies, and inpatient rehabilitation facilities. Further, HCFA must submit a report to the Congress by October 1, 1999, on a PPS design for long-term care hospitals. The statute also modified the existing prospective payment systems for hospital inpatient care and physician services. In addition, HCFA has proposed revising its prospective payment system for ambulatory surgical centers (ASCs). Finally, the BBA changed the method for determining prospective capitation payments for health care organizations that enroll beneficiaries in the new Medicare+Choice program.

Under the law, the Medicare Payment Advisory Commission (MedPAC) must review the design and implementation of these policies. In addition, we make annual payment update recommendations to the Congress for Medicare's payment systems (discussed in this report). To guide our analysis of payment issues in all of these settings, we have begun developing a payment policy framework. Our immediate goal is to lay out the issues that must be addressed in designing or updating prospective payment systems and a framework for thinking about them.[2] In the longer term, we intend to refine this framework and identify explicitly a set of consistent principles that policymakers should follow when they make payment policy decisions.

This chapter describes our policy framework by:

- outlining Medicare's payment objectives, the payment principles that flow from buying health care in local markets, and payment system design challenges for policymakers, and
- highlighting major design decisions, related payment system components, design options, and implementation issues.

The policy framework focuses on the issues policymakers confront in designing prospective payment systems. We illustrate key decisions and the factors that may influence choices among options by examining similar decisions that have been made in developing existing systems, such as those for hospital inpatient care and physicians' services. Because the same design issues must be resolved in setting payments for Medicare+Choice organizations, we also consider that payment system in this context. These illustrations suggest a set of common design questions that must be resolved in designing any prospective payment system. They also highlight some important design principles and show how their application may lead to different decisions across health care settings.

Payment policy objectives and environment

A framework for analyzing Medicare's payment systems must account for both payment policy objectives and the major features of the environment in which the payment systems will operate. Building a payment policy framework, therefore, raises several immediate questions:

- What are Medicare's payment policy objectives?
- What does buying health services from private providers in local markets imply for setting Medicare payment rates?
- What challenges must policymakers overcome in designing payment systems for multiple settings in a complex and dynamic health care delivery system?

Common design questions

What is Medicare buying in a particular setting?

What factors account for predictable variation in the cost of producing these products?

How should we determine the level of payment?

How would we know if payment rates were too high or too low?

What factors should be considered in adjusting the payment rates over time?

Are similar services or products available in another setting?

Under what circumstances should Medicare pay more for a service in one setting than in another?

Medicare's payment policy objectives

Medicare's primary goal is to ensure that its elderly and disabled beneficiaries have access to medically necessary acute care of high quality.[3] Federal spending to meet this goal is financed by a combination of payroll taxes,

1 Under prospective payment, a provider's payment is based on predetermined rates and is unaffected by its incurred costs or posted charges. Examples of prospective payment systems include the one Medicare uses to pay hospitals for inpatient care and the physician fee schedule.

2 Payments also could be based on negotiated rates or on amounts set by competitive bidding. This chapter focuses on prospective payment systems because Medicare is required by law to use that approach for most services.

3 Medicare also provides limited coverage of long-term care furnished in a skilled nursing facility or through home health visits; it does not cover custodial care.

general revenues, and beneficiaries' premiums. To minimize the financial burden on taxpayers and beneficiaries, Medicare has an obligation to purchase appropriate care as efficiently as possible. Thus, Medicare's payment policies should promote efficient production and distribution of acute care products and services.

Buying health care in private markets

Medicare buys covered products and services from providers who compete for resources in private markets. Consequently, Medicare's payment systems should strive to establish payment rates that approximate the competitive prices that would prevail in the long run in local health care markets.

If the program's payment systems were successful in meeting this objective, then its payment rates would be:

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

Setting the right price

Approximating long-run market prices is not an easy task, partly because no one knows what they would be. Theoretically, long-run market prices in a competitive health care market would equal providers' long-run marginal costs per unit. This suggests that Medicare should pay rates that are equal to providers' long-run marginal costs, as long as those amounts also cover their long-run average costs (Pauly 1980).[4]

In the short-run, however, providers' costs may be above or below their long-run marginal costs. Moreover, substantial discrepancies between Medicare's prospective payment rates and providers' short-run costs may lead to serious problems for beneficiaries or taxpayers. When providers' marginal costs for individual patients may differ substantially from Medicare's payment rates, providers have incentives to engage in risk selection, seeking only the least costly patients and avoiding those who are likely to need unusually expensive care.[5] When payment rates fall short of the marginal costs of providing additional services, providers have incentives to stint on the services or inputs used to produce care. Thus, rates that are below marginal costs might cause access and quality problems for beneficiaries. Conversely, when rates are set above marginal costs, providers have incentives to furnish too many services, thereby exposing patients to unnecessary health risks and creating unwarranted financial burdens for beneficiaries and taxpayers.

These potential consequences suggest that Medicare's payment rates should be consistent with efficient providers' marginal costs. Providers' costs are difficult to determine, however, because the available measures are based on accounting costs, which may differ from true economic costs. Further, most health care providers produce multiple products and some operate across two or more settings—hospital inpatient and outpatient care, for instance—making it difficult to disentangle the costs associated with specific services. Nevertheless, markets for most products and services appear to accommodate a fairly substantial range of price and cost variation. Consequently, Medicare's payment rates need only to fall within that range.

Payment rates, incentives, and unintended consequences

In designing a PPS, it is crucial to keep in mind the potential for unintended consequences. Just like 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 an incentive to improve efficiency for the products and services included in the payment rate.

Providers can lower the risk of loss, however, by reducing their costs or increasing their revenues in ways that are inconsistent with Medicare's goals. As mentioned, these include risk selection, stinting, and increasing the volume of services provided. But others are possible as well even when the payment rates are neither too low nor too high: unbundling the product by shifting some component services to another setting; using the gray areas of diagnosis and procedure coding systems to overstate the complexity of care and receive higher payments; submitting false claims; or ceasing to participate in Medicare.

Each of these strategies 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 costs generally encourage providers to respond appropriately to payment incentives. But one or more of these responses may become attractive if Medicare's payment rates depart substantially from efficient providers' production costs. Consequently, payment system design decisions frequently involve carefully considering how the available options may raise or lower the likelihood of unintended responses.

Challenges for policymakers

Designing new payment systems and updating existing payment rates for a variety of health care settings raise several challenges for policymakers. First, circumstances differ among settings, so one challenge is to recognize differences among types of providers, the services they furnish, the beneficiaries they serve, and the tools and information available.

4 Some local markets—for example, those that have only one hospital or one specialist physician—may not be competitive now or in the future. In these and some other situations, providers' long-run average costs may be higher than their long-run marginal costs. Because technology changes and capital assets deteriorate, however, Medicare's payment rates ultimately must cover providers' long-run average costs. Thus, in some instances, Medicare may have to set payment rates that are higher than the prices that might have prevailed in a hypothetical competitive market.

5 To act on this incentive, providers would have to be able to identify patient characteristics that predictably lead to relatively high or low marginal costs.

As later discussion will show, payment system design is largely driven by policymakers' understanding of the clinical characteristics of the products Medicare is buying in each setting and the main features of providers' cost structures.

A second challenge arises because the delivery of health care is complex. In a single episode of care, for example, beneficiaries may receive physician visits, hospital outpatient diagnostic procedures, a surgical procedure during a hospital inpatient stay, physical therapy in an inpatient rehabilitation unit, post-acute care in a skilled nursing facility, and home health visits. At various points during the episode, the same or similar services could be furnished in two or more settings in which providers are paid under different payment systems with potentially different payment rates and financial incentives.

This complexity means that policymakers must recognize the potential for overlap among settings and avoid introducing inconsistencies among payment systems that 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. Other factors being equal, Medicare should pay the same amount for identical services regardless of the setting in which they are furnished. In applying this principle, however, policymakers need to be sure that services with the same description are in fact identical. This would not be true if the patients served in alternative settings present different clinical risks or needs for support services that may legitimately affect providers' costs. The challenge of appropriately addressing potential overlaps among settings has been growing with the introduction of new organizational arrangements for the delivery of care.

The dynamism of the health care system raises a final challenge. Continuing advances in medical science and technology and innovations in the organization and delivery of care alter the services available, where they can be produced, and providers' costs of production. Medicare's administered pricing systems (and those used by other health insurers), however, lack the full complement of competitive market feedback mechanisms.

Normal market feedback mechanisms generate prices that lead providers and consumers to adjust their behavior in response to changes in supply and demand conditions. Health care markets are unusual, however, because insured consumers face drastically reduced prices in purchasing services and because consumers and their physicians are both usually separate from the payer. One result is that consumers' decisions about service use are often distorted. Another is that shifts in demand among consumers in response to changes in product content or in service availability across settings do not automatically alter insurers' payment rates.

Consequently, Medicare must adjust its payment rates over time to reflect changes in prices that otherwise would occur automatically in a competitive market. This means that mechanisms for updating the payment rates and related factors must be designed and implemented in each setting to respond appropriately to changes in underlying supply and demand conditions. To support this effort, Medicare must devote substantial resources to monitoring and evaluating changes in the clinical technology and organization of care. In addition, the program must monitor beneficiaries' access to services, the quality of care they receive, and other indicators that suggest when payment rates diverge too far from providers' costs.

Major design decisions

All prospective payment systems must ultimately resolve the same set of issues:

- **Establishing the unit of payment.** Will providers be paid for an individual service or a bundle of services, such as an inpatient day, an inpatient stay, an episode of care or illness, or a month of care?
- **Establishing relative values.** How will payment rates based on the selected unit of payment be differentiated among distinct services, bundles of care, or beneficiary characteristics to recognize appropriate and predictable differences in providers' costs?
- **Defining local input price adjustments.** How will payment rates be adjusted to recognize differences in local prices for inputs such as labor and capital? Local input price differences, which reflect variations in supply and demand conditions among market areas, may substantially raise or lower providers' costs. Payment rates must be adjusted accordingly to avoid creating arbitrary gains and losses for providers based solely on their location.
- **Defining other rate adjustments.** How will payment rates be adjusted to accommodate unusual circumstances of providers or special characteristics of services and beneficiaries that affect providers' costs but are not accounted for by the basic payment model? One example is how to adjust the payment rate when physicians perform surgery in an OPD or an ASC, thereby avoiding some costs that otherwise would be incurred in their offices. Another is how to adjust the payment rate when a patient's care turns out to be unusually costly.
- **Setting the initial level of payment.** How will the initial level of the payment rates be determined? Options include providers' historical costs or past Medicare spending for services in the particular setting.
- **Updating the payment rates over time.** How will payment rates and related factors be updated to reflect changes in technology, practice patterns, and market conditions? Update mechanisms must be designed to detect changes in these factors and make appropriate revisions to each of the main payment system components while maintaining the affordability of the program.

Policymakers' decisions on these issues define the components of a PPS. The essential character of any PPS primarily reflects choices on the unit of payment and the relative values. These two interrelated

General prospective payment formula

In a prospective payment system, the payment rate for a specific product in a particular market area is determined by the following general formula:

Payment rate for product A in market area B =

Initial base payment amount

- **x update factor**
- **x input-price adjustment factor for market area B**
- **x relative value for product A**
- **x other rate adjustment factors**

The initial base payment amount is usually a national dollar amount for a specific year that reflects policymakers' decisions on the unit of payment and the appropriate initial level of payment for the average unit. The update factor adjusts the initial base amount for inflation and other factors to set the base level of payment for the rate year. The input-price adjustment factor then raises or lowers the national base amount to reflect the relative level of input prices in the particular market area compared with the national average. Next, the relative value adjusts the market-specific base amount to reflect the expected relative costliness of the particular product compared with that of the average unit. Finally, the local rate for the specific product may be modified by one or more additional rate adjustment factors designed to accommodate unusual characteristics of the provider, the service, or the specific patient.

decisions define the products for which Medicare will pay. They also determine the scope of the payment system's incentives and its potential power to influence service use and program spending.

Establishing the unit of payment

Choosing a unit of payment depends on several issues:

- How well can the product be defined?
- Are effective product classification systems and related data available?
- How will policymakers balance trade-offs between the scope of the payment incentives and potentially undesirable provider responses?
- Is it desirable to bundle services furnished by complementary providers?
- What supporting rules are needed to define the boundaries of the payment unit?

How well can the product be defined?

One of the most important factors influencing the unit of payment decision is how well the product or service can be defined. If the product cannot be defined well, setting payment rates that accurately reflect providers' expected costs will be difficult, and providers' gains and losses could be largely unrelated to their performance. It also would be difficult in this case to monitor providers' performance and ensure that they deliver what Medicare wants to buy. Moreover, a PPS based on a poorly defined product gives providers both incentives and opportunities to benefit financially without improving efficiency.

Ideally, the unit of payment should match the unit of service, which reflects the way providers think about the product and provides context for their decisions about care.[6] The unit of service for hospital inpatient care, for instance, is a hospital stay—a completed episode of acute inpatient care, beginning at admission and ending when the patient no longer needs the acute level of care hospitals offer. In contrast, the unit of service for physician care could be thought of as either an episode of care or as an individual instance of service.

Defining and measuring the product or service requires identifying the clinical factors that account for variation in the content and duration of care. In addition, reliable information on those factors must be readily available at the appropriate level (service, episode of care, or beneficiary). Lack of sufficient knowledge and information has often prevented policymakers from using a larger payment unit in some settings. For example, the recently implemented SNF payment system is based on a per diem payment unit rather than a complete stay because the clinical and other factors that account for differences in patients' lengths of stay are not well understood. Similarly, payment for home health care is based on visits rather than episodes of care because no one knows how to appropriately differentiate home care episodes.

Are effective product classification systems and related data available?

Using a particular unit of payment requires a compatible and effective classification system that identifies distinct services, patient care products (types of days or cases), or beneficiaries that are expected to require different amounts of providers' resources. In the physician fee schedule, this function is performed by HCFA's Common Procedure Coding System (HCPCS). The hospital inpatient PPS is based on the diagnosis related groups (DRG). The Medicare+Choice program classifies beneficiaries based on their demographic characteristics and institutional status and soon will add health status. In each instance, the categories in the classification system define the products for which Medicare will pay.

6 The unit of payment may be changed intentionally to alter the mindset of providers. In the early 1980s, HCFA replaced per diem limits on hospitals' allowable costs for routine inpatient care (room, board, and nursing care) with per case payments, partly to stimulate changes in hospitals' and physicians' thinking about the production of inpatient care.

The need for an effective classification system can be seen by considering how hospitals' financial incentives would change if Medicare paid a single fixed price for all inpatient stays. Although hospitals still would face strong incentives to reduce the cost of care for any patients they might serve, they also could realize large gains by engaging in risk selection, admitting only patients with relatively low-cost conditions. Conversely, they would experience large losses for patients with high-cost conditions, for example, those who required a bone marrow transplant or those with severe burns. Consequently, a per case PPS without an effective classification system like the DRGs would surely create access problems for beneficiaries with serious illnesses.

Effective classification systems generally meet two essential criteria. First, they account for a reasonably high proportion of the predictable variation in providers' costs. A successful system thus captures most of the systematic cost differences that result from clinical or other differences among services, patients, or beneficiaries. To the extent that this criterion is not met, providers have incentives for risk selection.[7] Equally important, providers that have established a reputation for expertise may attract patients who are more seriously ill and more costly than the average patient. When the classification system fails to capture such severity differences, these providers may be penalized because they cannot balance losses on high cost patients with gains from low cost ones.

Second, the classification variables, such as diagnoses or procedures, must be reasonably objective and easily monitored. If this criterion were not met, providers would have incentives to increase their revenues by manipulating the classification variables (called code creep) so that services or patients were assigned to higher paid categories.

The relevant information—procedures, patient diagnoses, or beneficiary characteristics—needed to assign services, patients, or beneficiaries to the appropriate classification categories also must be readily available. The lack of relevant data on beneficiary health status has retarded development of more effective classification systems and prevented payment system improvements in most post-acute care settings and in Medicare's managed care program for many years.

How will policymakers balance trade-offs between the scope of incentives and potentially undesirable provider responses?

Other factors being equal, policymakers should choose a large unit of payment over a small one because it gives broader scope to providers' incentives for efficiency. This choice, however, also affects the potential undesirable actions providers might take. Whether this trade-off is important largely depends on the extent to which providers control product content and volume.

The scope of providers' incentives for efficiency depends on the size of the product or unit included in the price. Larger units include more services, thereby increasing the provider's opportunity to economize on the mix and quantity of services and related inputs used to produce the unit. Thus, a hospital inpatient stay or a month of care provides broad incentives for efficiency because many services are included in the product. In contrast, a narrow unit of payment—individual services, such as office visits or X-rays for instance—provides narrower incentives for efficiency. The provider's opportunities to reduce costs are limited to altering the mix and quantity of inputs used to produce each service.

Providers may respond to these incentives as intended, or some may respond in less desirable ways, such as stinting on services or inputs and increasing the number of units they furnish. The potential actions they might take, however, depend on the size of the payment unit, their control over the product, and the likelihood of oversight.[8]

When providers have direct control over product content and volume, a small payment unit—the service for instance—generally creates relatively little concern about stinting, but substantial concern about potential increases in the volume of units. Conversely, a large payment unit usually generates more concern about potential stinting but less about unintended changes in volume. Large payment units, such as hospital stays, generally include broad opportunities for stinting, but they often involve significant risks for patients and substantial costs and thus are more likely to attract oversight and review.

Providers' control over content and volume varies among care settings. In many facility settings, such as hospital inpatient units or ambulatory surgical centers, physicians' orders largely determine both the mix and quantity of services furnished and the number of patients served. In these settings, the potential for adverse responses to payment incentives by the facility provider may be limited to some degree by physician oversight. The strength of physician influence varies among settings, however, reflecting the extent to which they actively direct the care patients receive. Thus, the potential for both stinting on services and unintended volume growth might be of greater concern in a SNF payment system based on a per diem payment unit, for instance, than it would be in a hospital PPS with a per stay payment unit.[9]

Physicians' roles have been changing, however, raising some uncertainty about whether the traditional independence of their patient care decisions may be eroding. This uncertainty reflects physicians' growing interrelationships with

7 Medicare generally does not pay for physicians' services based on episodes of care because it lacks an effective episode-based classification system. One exception is surgical episodes in which pre- and post-operative office visits are bundled together with the surgical procedure and paid under a global surgical fee. Another is end-stage renal disease; Medicare pays for physician management of dialysis services on a monthly capitation basis.

8 The likelihood that providers would take undesirable actions also may be affected by other factors, such as related potential costs (loss of reputation, for example), how well the product is defined, and the degree of consensus about its medical necessity. Personal and professional ethics and values also play a significant role.

9 The potential for unintended volume growth has been a major concern in the physician fee schedule and in other ambulatory care settings where the payment unit is the individual service.

other providers, especially hospitals and health care organizations, through contractual incentives that affect their compensation or through practice ownership.

Is it desirable to bundle services furnished by complementary providers?

Although a larger payment unit generally is preferred over a smaller one, the larger unit may be rejected because of concerns about the potential effects on patients. In the hospital inpatient PPS, for example, physician services related to a hospital inpatient stay could have been combined with the hospital facility services included in each DRG. This probably would have had little effect on the way in which diagnoses and procedures were grouped in defining the DRGs, but it certainly would have affected the relative values across DRGs and the initial level of payment.

Paying the combined rate to physicians would have potentially exposed them to high levels of financial risk. Although hospitals were better able to bear the financial risk, many physicians were concerned that giving hospitals control over the combined payment would compromise their independence in making patient care decisions. In the end, policymakers were persuaded that preserving physicians' independent patient advocacy role provided valuable protection for Medicare beneficiaries and outweighed potential efficiency gains that might have been obtained by using a broader payment unit.

What supporting rules are needed?

Payment policy cannot stand alone. Policymakers also must define the boundaries of the payment unit because providers facing a fixed payment rate have financial incentives to unbundle the product by billing separately for individual services that should be included in the payment unit or by shifting some of these services to another setting.

In the hospital inpatient PPS, for instance, hospitals have a strong incentive to shift diagnostic services to the outpatient department or a physicians' office. Hospitals also can reduce inpatient costs by discharging patients earlier to a long-term care hospital, rehabilitation facility, SNF, or home health care, all of which are paid under separate payment systems. SNFs have similar incentives to reduce per diem costs. Their ability to realize savings depends on how the boundary is defined between the bundle of services a SNF is expected to furnish and services that may be provided by an independent provider or in another setting—diagnostic imaging services furnished in a nearby hospital outpatient department, for instance.

To limit potential unbundling, HCFA has implemented a variety of rules. For example, hospital outpatient services furnished within 72 hours before a patient's admission for care are assumed to be part of the inpatient stay and may not be billed separately under the hospital outpatient payment system. To mitigate shifting of services at the end of a stay, hospitals' per discharge payments are reduced in 10 DRGs when a patient is discharged to a rehabilitation facility, long-term care hospital, SNF, or to related home health care after a stay that is two or more days shorter than the national average length of stay for the DRG.[10] The 10 DRGs include categories in which a high proportion of Medicare patients go on to use post-acute care.

Establishing relative values

Relative values measure the expected costliness of a unit in each classification category compared with the overall average costliness of all units.[11] Relative values may be structured in different ways depending on policymakers' understanding of the clinical components of care and providers' cost structures. Thus, for each setting, policymakers must decide what components are combined to produce the product, how those components vary among product categories, and what factors are likely to affect efficient providers' component production costs. These decisions produce a model of provider cost structure, which identifies a set of factors that are expected to account for variation in the unit cost of services.

The model of hospital costs that is implicit in the hospital inpatient PPS, for example, is relatively simple. Hospitals' costs are assumed to be the sum of operating and capital costs. Each component is expected to vary in the same way across DRGs. Consequently, only one set of DRG relative values is needed to determine both the operating and capital components of a hospital's payment rates for all DRGs.[12]

The model of provider cost structure implicit in the physician fee schedule is more complicated. The value of each physician service is assumed to include three parts: physician work, practice expenses, and professional liability insurance costs. The value or cost of each component is expected to vary across the service categories of the HCPCS coding system, but the distribution is different in each instance. Consequently, three sets of relative values are needed to determine the

10 Such early discharges are considered transfers, and the hospital is paid based on a per diem rate up to a maximum of the full per discharge payment rate for the DRG.

11 Relative values also may be thought of as measuring the relative worth of each product or service compared with that of all services in the particular setting. Conceptual distinctions between cost, worth, and value, however, generally have little practical significance.

12 Other factors differ between the operating payment rates and those for capital—geographic input-price adjustments for example—but the DRG relative values are the same. Although it is highly likely that the distribution of capital costs among DRGs differs from that for operating costs, it would be difficult to measure accurately capital costs by DRG. Moreover, policymakers anticipated that the capital and operating payment rates eventually would be combined in a single rate for each DRG. Consequently, they chose to use the same relative values for both components.

payment rate for a service.[13]

In the Medicare+Choice payment system, the relative values are based on a risk adjustment model that estimates expected annual spending for all Medicare-covered services given a beneficiaries' demographic characteristics, eligibility for Medicaid benefits, and institutional status. HCFA has proposed using a new model that also takes into account beneficiaries' health status as indicated by the principal diagnosis for the most costly hospital stay (if any) they had during the previous year.

Constructing relative values

Relative values are often based on estimates of providers' costs. HCFA originally developed the DRG relative values for Medicare's hospital inpatient PPS, for example, using estimates of hospitals' average costs per case in each DRG. These estimates were derived from provider-specific billed charges and cost to charge ratios for each component type of service, adjusted to reflect national average input price levels.[14] Relative values for OPD services in HCFA's proposed outpatient PPS are determined similarly.

In the Medicare+Choice payment system, relative values are based on estimated average annual spending for Medicare-covered services for each beneficiary category. This method is appropriate because spending for covered services accounts for the overwhelming majority of a health plan's costs. These estimates are developed from HCFA's annual claims database, which includes all fee-for-service bills paid under the traditional program.

Sometimes, however, the data needed to estimate providers' costs at the product or component level are unavailable. In these instances, policymakers have used two alternative approaches. Occasionally, relative values have been based on a measure that reflects a major component of costs. Relative values for different categories of patient days in the recently implemented PPS for SNF services, for instance, were based on data from staff time studies. Although the mix and quantity of staff time accounts for much of the cost of a day of SNF care, this approach may result in payment errors if other components of costs follow a different pattern. Pending collection of data on actual cost differences among services, physicians' historical charges were used as a proxy for costs in developing relative values for the practice expense and professional liability insurance components of the physician fee schedule.

In other instances, relative values have been based on expert opinion. Service-specific data on resource use for the physician work component are almost unimaginable. To fill this void, panels of physicians assigned relative values to individual services by comparing them with a set of reference services usually performed by different physician specialists. These values were intended to measure the relative amount of work for each service based on several criteria, such as the amount of physician time, intensity of effort, skill, and risk to the patient, compared with those for the reference services.

Defining local input price adjustments

Input-price differences among market areas may account for 50 percent or more of the observed nationwide variation in providers' costs for a given product. Consequently, an effective input-price adjustment is essential in setting appropriate payment rates for each market area.

Input-price adjustments are made using a price index, which compares prices in each market area with the national average. The index is applied to raise or lower all or a portion of the base payment amount to reflect each area's input-price level. The price index is based on two types of information: an input-price data set, which shows the average price in each market area for each type of resource; and a set of weights indicating the relative importance of each input in the production process, as indicated by its share of providers' costs.

Product components that are affected by input-price variation

Designing appropriate input-price adjustments requires decisions on three issues. First, policymakers must decide which product components—and corresponding portions of the base payment amount—should be adjusted for local price variation. This decision is based on knowledge of the production process, which identifies components whose inputs vary in price among local markets, and the proportion of component production costs that are affected. In the hospital inpatient PPS, for instance, HCFA has determined that 71 percent of hospital operating costs are affected by local variation in prices for labor. The other 29 percent is largely made up of supplies and minor equipment items, which are assumed to be purchased in national markets and thus need no adjustment.[15]

Defining input market areas

In addition, policymakers must decide how market areas will be defined. This is critical both for measuring price differentials for specific inputs and for determining the adjustment that applies for any provider. HCFA generally has used metropolitan statistical areas and statewide rural areas to define market areas for most facility PPSs, such as those for hospitals, ASCs, and SNFs. In the physician fee schedule, market areas in some states are defined by administrative regions (called localities), and in others they are statewide. In the Medicare+Choice program, market areas are defined by collections of counties

13 Anesthesia services are priced separately using a single set of relative values based on the sum of a fixed component and a time-based component, which varies by procedure.

14 Later analysis showed that adjusted costs per case were highly correlated with adjusted charges among DRGs. Consequently, DRG relative values have been based on billed charges for more than a decade.

15 A cost of living adjustment is applied to adjust the nonlabor component for hospitals in Alaska and Hawaii.

representing where each county's resident fee-for-service beneficiaries received care.

Measuring input prices

The third issue is how to measure input prices in each area. For each setting, policymakers must choose the specific inputs for which prices will be measured; whether to use prices paid only by providers in a specific setting or prices for the same or similar inputs paid by a broader spectrum of providers; and how to account for differences among settings in the mix of inputs used. In recent years, HCFA has annually collected data on total wages and hours from most facilities, such as hospitals and SNFs. HCFA uses these data, without adjusting for differences in the mix of occupations employed, to calculate wage indexes for each type of facility in more than 300 market areas. The lack of an adjustment for occupational mix differences may cause the hospital and SNF wage indexes to overstate substantially the actual relative level of wages in some market areas and understate it in others.

For the physician fee schedule, HCFA calculates separate geographic practice cost indexes for physician work, practice expenses, and professional liability insurance expenses for 89 payment localities. To calculate these indexes, HCFA uses data from the decennial census, residential rent indexes, and other sources. Because each service is described by separate relative values that account for its particular mix of physician work, practice expenses, and professional liability expenses, the potential for systematic distortions across areas may be lower than that in the hospital and SNF wage indexes.

In the Medicare+Choice program, the most relevant inputs are the services that health plans purchase from physicians, hospitals, outpatient facilities, SNFs, and home health agencies. However, policymakers cannot easily obtain data on the prices health plans paid for a representative set of services, and many market areas have no health plans serving Medicare beneficiaries. Consequently, an input-price adjustment based on service prices is probably not a reasonable option in the near term.

Providers in virtually all health care settings employ workers in many of the same occupations, although the proportions probably vary substantially among settings. An alternative to the current approach thus might be to collect occupation-specific wage data from a representative set of providers operating in all health settings in each market area. These data then could be used with occupation cost shares for specific settings to obtain a set of indexes that could be applied in individual payment systems.

Defining other rate adjustments

Policymakers must decide whether and how to adjust the payment rate for a service or bundle of services to accommodate unusual characteristics of the patient or the services provided, the provider, or the market area in which the provider operates. Generally, rate adjustments should be applied for factors that would affect an efficient provider's costs and are beyond the provider's control. In some instances, policymakers also have added payment adjustments to provide explicit support for certain socially valued activities.

Special characteristics of patients or services provided

The product classification systems used in setting payment rates often fail to capture all of the patient characteristics that may affect providers' costs of delivering care. Some of these characteristics may be predictable. For example, extremely frail patients or those with severe cognitive impairment may require extra assistance for services as simple as a chest X-ray. In other instances, higher costs may be triggered by the occurrence of random events. Patients who suffer serious complications, such as a pulmonary embolism or a stroke during a hospital stay, can double or triple the hospital's costs compared with those for typical patients with the same underlying illness.

A payment system that fails to recognize predictable additional costs would give providers strong disincentives to treat patients who have high cost characteristics. Further, the extra costs associated with random catastrophic events could threaten providers' financial viability and thus beneficiaries' access to care.

In the hospital inpatient PPS, the latter problem is addressed by an outlier policy, which operates much like a mandatory reinsurance policy. Medicare makes additional payments to hospitals when costs for a patient exceed a DRG-specific loss threshold. The difference between the loss threshold and the usual DRG payment rate is a fixed loss amount, which acts like a deductible that must be exceeded before outlier payments begin. Payments above the deductible loss amount are subject to a 20 percent coinsurance (borne by the hospital) because Medicare pays only 80 percent of the additional amount. Outlier payments substantially reduce the losses hospitals otherwise would incur on unusually high cost patients, thereby limiting hospitals' incentives to avoid those who are seriously ill. These payments are financed by an equivalent aggregate reduction in all DRG payments, thus distributing the burden of unusually costly patients among all hospitals in proportion to their DRG revenue.

The physician fee schedule includes modifiers that a physician may apply to raise the physician work relative value when the services provided are greater than those usually required for a procedure. Other fee schedule modifiers may apply when a return trip to the operating room is required for a related or unrelated procedure during the postoperative period.

The opposite situation also may arise—when not all of the services included in the unit of payment are needed. This may occur, for instance, when a patient is transferred from one hospital to another after only a few days. To reflect the transferring hospital's lower costs, payment for these cases under the inpatient PPS is based on a DRG-specific

per diem rate, which is equal to the hospital's full DRG payment rate divided by the national average length of stay for the DRG. This policy recognizes that the first day of care is usually much more costly than subsequent days of inpatient care. The transferring hospital thus receives twice the per diem rate for the first day and the per diem amount for each additional day, up to the full DRG rate.

Analogous adjustments are made in the physician fee schedule for situations in which the physician's service is less than that usually required. For example, modifiers are applied to reduce the relative value for the procedure if the physician acts as an assistant surgeon or if review of the medical record indicates that the usual services were not fully furnished. For many services, the practice expense component of the physician's payment is reduced by a site-of-service differential when the service is provided in a OPD or an ASC rather than the physician's office.

In the Medicare+Choice payment system, payments to an organization are reduced substantially when an enrolled beneficiary is employed and covered under the employer's health insurance plan. Under the law, the employer is primarily responsible for making payments to the plan and Medicare is considered the secondary payer. In this case, the organization's costs are unaffected, but it would be overpaid if Medicare made its usual payment.

Special characteristics of providers or market areas

Some providers offer specialized types of care that are not available from otherwise similar entities, thereby incurring unusual costs. Hospitals that provide organ transplant surgery, for example, bear highly variable costs for organ acquisition. Failing to recognize this extra burden would give hospitals strong incentives to cease offering transplant services. Consequently, these costs are excluded from the hospital inpatient PPS and paid separately based on the reasonable amount actually incurred. Other hospitals treat a disproportionate share of patients with end-stage renal disease (ESRD). To preserve access to care, the payment system accounts for the extra costs these facilities incur in providing dialysis services for ESRD patients when they are treated for unrelated conditions. The inpatient PPS thus makes extra payments based on the weekly cost of dialysis to hospitals in which more than 10 percent of Medicare patients have ESRD but are admitted for unrelated care.

Other providers serve sparsely populated or economically depressed market areas. One example is hospitals that are the sole providers in their communities. Another is physicians who practice in urban or rural health professional shortage areas. These providers may face higher costs or other disincentives to continue serving such markets. Both the hospital inpatient PPS and the physician fee schedule provide special treatment for providers in these circumstances.

Similarly, health care organizations participating in Medicare's managed care program (now the Medicare+Choice program) have been reluctant to serve counties with low payment rates. These counties may be unattractive because they have relatively small populations of beneficiaries or few hospitals and other providers with whom organizations might contract. To overcome these disadvantages and improve beneficiaries' access to health plans, the Congress established a floor payment rate, raising payment rates for some counties by 20 percent or more.

Explicit subsidies for socially valued activities

Developing a prospective payment system forces policymakers to make explicit decisions about whether to provide subsidies for certain socially valued activities. Before the hospital inpatient PPS was adopted, Medicare reimbursed hospitals for its share of the costs they incurred for certain activities, such as medical education and training programs. Unpaid costs incurred by hospitals that serve large numbers of poor patients generally were not reimbursed by Medicare unless they were related to the care furnished to Medicare patients. When the Congress adopted the inpatient PPS, it decided to make extra payments to hospitals to support both of these activities.

Extra payments for these activities generally have not been made in other settings. HCFA's proposed hospital outpatient PPS, for example, does not include payment adjustments for hospitals that operate teaching programs or those that serve a disproportionate share of poor patients (see Chapter 6). Moreover, policymakers generally have not been willing to adopt payment adjustments to support costs associated with other potentially valuable activities, such as hospitals' participation in trials of experimental therapies.

Setting the initial level of payment

Given the decisions they have made on the unit of payment, relative values, and payment adjustments, policymakers must establish the initial level of the base payment amount in each payment system. Combined with actual service use by type of service and location, the initial payment amount will determine the level of the payment rates, total program spending for the setting, and the level and distribution of beneficiaries' related copayments in the first payment year.

The base payment amount represents the amount Medicare pays for a standard service, product, or beneficiary in an area with national average input price levels. In the hospital inpatient PPS, for example, the base payment amount is Medicare's payment for an average case (a case in a DRG in which the relative value is 1.0) in a hospital located in an area with national average wage rates (the wage index equals 1.0), if no other adjustments are applicable.

Major issues

The obvious issue is how to calculate an initial value for the base payment amount that is consistent with earlier payment design choices. The answer depends on three issues:

- whether pertinent information on providers' costs and payments, is available,
- whether, and how, to allow for regional differences in practice patterns, and
- whether the proposed payment system will be constrained to meet a specified aggregate spending target. A spending target may maintain aggregate spending at the level anticipated under the previous payment system (called budget neutrality) or achieve specified budget savings.

Availability of pertinent information. HCFA has used providers' reported costs and claims data to develop cost-based payment amounts when cost data have been available—for example, in payment systems for services provided in hospital inpatient and outpatient facilities, ASCs, SNFs, and home health agencies. When cost data have not been available, or relevant, HCFA has used data on claims payments and total spending instead, for instance in the physician fee schedule and in Medicare's managed care program.

Regional differences in practice patterns. Providers located in different regions may use varying amounts and mixtures of services and inputs to provide patient care.[16] As a result, providers' costs for a standard service unit or product may differ substantially among regions. In this case, policymakers face three options. One is to set payment rates based on a national base payment amount, thereby ignoring regional cost differences. With the same aggregate spending, this option would likely result in substantial redistribution of payments among providers based on their regional location. A key question in evaluating this option is whether any resulting changes in practice patterns would be harmful to beneficiaries. The answer depends on whether more costly practice patterns are associated with substantial improvements in patient outcomes.

A second option is to set payment rates based on separate regional base payment amounts, thereby fully recognizing regional differences in average cost. This approach would likely result in relatively little payment redistribution, and providers in all regions would face comparable incentives to alter their practice patterns to improve efficiency. On the one hand, this approach might seem attractive if higher cost practice patterns were associated with better outcomes. On the other hand, it would tend to freeze practice patterns for providers and beneficiaries in low cost regions, preventing them from realizing available quality improvements by adopting the practice patterns used in high cost regions.

The third option is a compromise, blending national and regional base payment amounts in specified proportions. This option may be used as a transition mechanism to blend national and regional amounts in varying proportions over time, thus allowing providers a reasonable period to make practice adjustments. Moreover, the transition may end with a single national payment amount or with a specific permanent blend of national and regional amounts. Policymakers might choose a permanent blend if they were uncertain about the extent of the association between quality and cost.

Two examples illustrate how policymakers have addressed this issue. In the early 1980s, hospital inpatient operating costs per case exhibited substantial regional variation, partly because average lengths of stay were about twice as long in the Northeast and the Midwest as they were in the South and the West. After much debate, the Congress decided to include regional and national payment amounts in a transition mechanism that also included updated hospital-specific base year costs. The four-year transition ended with a PPS based on separate urban and rural base payment amounts which reflected a judgment that regional differences in practice patterns were not strongly associated with quality differences.

The second example concerns Medicare's original risk contracting program. Policymakers initially decided that managed care organizations should be able to provide all Medicare-covered services to beneficiaries in return for 95 percent of the estimated monthly per capita amount Medicare would expect to spend in the traditional fee-for-service program in each county. This decision recognized the full effects of differences in fee-for-service practice patterns on county per capita spending. For example, monthly per capita payment rates for managed care organizations in 1997 ranged from $221 to $767 among counties, with practice variation accounting for roughly 30 to 40 percent of the total variation (ProPAC 1997).[17]

The Congress revisited this issue in the BBA and decided to reduce substantially payment variation among counties by blending each county's updated base year payment rate with an input-price adjusted national average payment rate. At the end of the five-year transition period in 2002, the updated county and national rate components will each account for 50 percent of the county payment rate, thus recognizing one-half of the practice pattern variation in traditional Medicare spending among counties.

Constraining the payment amount to meet a spending target. A budget neutrality requirement or other spending target shifts the policy focus from concerns about how the initial base payment amount should be developed to the assumptions that are made to ensure that actual spending reaches the target. This shift in focus occurs because a spending target, together with the other components of a payment system's design, fully determines the initial level of the base payment amount.

16 This variation may have developed in response to differences among market areas in the supply of specific resources or as a result of historical factors, such as state policies, that influenced the organization of care. Long-term care hospitals and ASCs, for example, tend to be highly concentrated in certain regions.

17 The Prospective Payment Assessment Commission (ProPAC) estimated that adjusting the county payment rates for variation in input prices would reduce the range by roughly one-half. The remaining variation comprises some combination of unmeasured differences in average risk (expected costliness) for the beneficiaries in each county and differences in the mix and quantities of services used (practice variation). If the former represents roughly 10 to 20 percent of the total variation, the latter must account for 30 to 40 percent.

A spending target is sufficient to determine the initial base payment amount because of the way in which targets are implemented. First, HCFA develops a projection of the expected aggregate program payments that would be made under the current payment system during the initial year of the new system. This spending target is generally based on the most recent claims (and cost) data available and anticipated trends in factors that are expected to affect service use and costs in the projection year. HCFA then develops a similar projection of total program spending anticipated under the new payment system. This projection is based on the same data but takes into account the payment rates in the new system, and anticipated responses to those rates by providers and beneficiaries. Although aggregate spending under the new system cannot be estimated without plugging in an initial payment amount, this amount is not really needed. Because the spending target is known, HCFA can infer what the initial payment amount would have to be, given its data and assumptions, to produce projected spending equal to target spending.

To project spending under the new system, HCFA must decide how providers are likely to change their behavior in response to altered payment incentives. Among other responses, providers may unbundle services, improve the quality and completeness of diagnosis and procedure coding, or increase the volume of service units they furnish. All of these actions would increase spending within the particular setting, or in the case of unbundling, in other settings. HCFA often tries to capture the overall effect of such responses in a behavioral offset assumption. In implementing the physician fee schedule, for example, HCFA assumed a 50 percent behavioral offset; 50 percent of the savings that otherwise would accrue from the new system would be lost to the combination of these responses. This assumption played an important role in determining the initial level of the conversion factor and thus the level of physicians' fees.

Setting the initial payment amount in the absence of a spending target

Without a budget neutrality requirement or other spending target, policymakers must decide how to determine the initial level of the base payment amount using data on providers' costs, paid claims, and annual program spending. Three methods generally have been used. All three require prior development of the product classification system, relative values, and payment adjustment factors that will be applied in the proposed payment system.

The first method uses providers' historical cost information, Medicare claims data for the relevant services or products, and the proposed payment system components. HCFA combines these elements to build up a base payment amount for a standard product or service. Variations on this approach have been used to set base payment amounts for the hospital inpatient, outpatient, and SNF payment systems.

The second method uses claims data for all covered services, demographic characteristics for all fee-for-service beneficiaries living in each county, and relative values for demographic categories. HCFA uses these data to estimate per capita program spending for a standard beneficiary (one who has national average demographic characteristics) in a geographic area and in the nation. This approach has been used to establish a base payment amount per enrollee for each county in Medicare's managed care program.

The third method is based on claims data, estimated total spending for the relevant services (including both program spending and beneficiary copayments), and the proposed payment components. As in the budget neutrality calculation described earlier, HCFA combines these elements to infer the base payment amount that would generate the same expected total spending. This method has been used to establish conversion factors for the physician fee schedule.

Building initial payment amounts using providers' costs and claims

The details of developing a base payment amount for the first payment year would vary somewhat according to the choice of method and the payment design decisions made earlier for a particular setting. HCFA has frequently used the first method based on cost and claims data because almost all types of facilities have been paid on the basis of incurred costs, making cost data for individual providers readily available. Using this method, however, raises three sets of issues:

- **Adjusting providers' base year costs.** Policymakers must decide how to adjust providers' reported base year costs to reflect earlier policy decisions about specific cost components and to improve comparability among providers. Cost elements that will be paid separately should be excluded from each provider's costs. Comparability may be improved by adjusting unaudited costs for the average effect of auditing and all providers' costs to reflect a common fiscal period rather than provider-specific reporting periods.
- **Standardizing for product mix, input prices, and other payment adjustments.** Policymakers also must decide how to adjust the revised provider-specific cost data to remove cost differences that reflect variations in service or product mix, local input-price levels, and other activities for which special payment adjustments will be made. These adjustments are necessary to make the base payment amount consistent with the various payment adjustments included in the payment system.
- **Computing and updating the base year amount.** The remaining decisions involve how to compute the base year amount per unit and update it to the first payment year. Policymakers could decide, for example, to compute the base year per unit amount using a simple

average, a volume-weighted average, or the median of providers' per unit standardized costs. Alternatively, policymakers could attempt to identify a subset of relatively efficient providers and use only their standardized costs to compute the base year amount per unit. Identifying efficient providers generally has proven to be difficult, however, partly because of the need to control for potential differences in product quality. The base year standardized amount per unit also must be updated to the first payment year.

Updating the payment rates and related factors

Once a new payment system has been implemented, policymakers must decide how to update the payment rates and related factors to reflect changes in technology, practice patterns, and market conditions. Thus, policymakers must develop methods and data sources for updating three sets of payment components: the base payment amount, the classification system and relative values, and the various payment adjustments.

Policymakers also must decide how often each payment component should be updated. This depends on how rapidly market conditions, technology, and other factors change. In most payment systems, the base payment amount has been updated annually to reflect inflation in input prices and other factors that are expected to alter the level of providers' unit costs in the forthcoming year.

The timing of updates may differ for other payment components. For example, although input prices may rise annually with inflation, the relative structure of prices across market areas may change less rapidly. Consequently, input-price indexes may not need revision more often than every three or four years. Similarly, the relative costliness of different products may be affected by changes in technology and practice patterns, but this is usually a slow process. The classification system and relative values in many settings may thus need only minor revisions each year, with major revisions at longer intervals. Some of the other payment adjustments, such as outlier loss amounts for instance, may require annual updates, while others may be revised rarely, if at all.

Updating the base payment amount

Among these update issues, the lion's share of policymakers' attention has been focused on how to determine annual updates to the base payment amount in each payment system. This focus reflects the powerful role the base amount plays in determining the level of the payment rates and its strong influence on total program spending.

It is important to note that the update affects all payment rates equally. Although it influences the total amount of spending for a class of services or products, the update does not affect the distribution of spending among providers or regions. Consequently, the update has nothing to do with the question of whether Medicare's payment rates are at the right level for any specific service or in any particular market. Rather, the focus is on two questions:

- Is the overall national structure of the payment rates at the right level?
- What factors should be taken into account in deciding how much to change that level over time?

Payment updates often are used to address both questions at the same time. It is important to keep these questions distinct, however, because each requires different types of information and different judgments. The first question asks policymakers to consider what has been happening in the recent past that might signal a substantial divergence between the base payment amount and providers' current costs. The answer is important because payment rates that are too low may lead to a reduction in beneficiaries' access to care or the quality of care they receive, while rates that are too high may encourage overproduction of services, which would burden beneficiaries and taxpayers.

If the analysis suggests that the base payment amount has strayed too far from providers' costs, then policymakers should make a corresponding adjustment. This is sometimes called rebasing because a similar adjustment would result if providers' most recent cost data were used to recalculate the base payment amount. Adjusting the base rate in this way does not recoup past over- or under-payments to providers. Rather, it simply makes the base payment rate more consistent with providers' costs in the future.

The second question asks policymakers to consider what objectives they want update policy to achieve. Update objectives may be limited to keeping the payment rates consistent with providers' costs, thereby focusing attention on factors that should legitimately affect those costs in the forthcoming year. Alternatively, policymakers also may seek to control growth in program spending for a particular set of services. This involves considering whether recent spending growth has been above or below the desired level and adjusting the update appropriately to rectify any discrepancy. In this case, policymakers use payment updates deliberately to signal providers that they have been producing too many or too few services.

These decisions about update objectives suggest the kinds of factors that should be considered in determining how much to raise payment rates for the forthcoming year. Assuming that the base payment amount is at the right level today, policymakers can use their knowledge of the recent past and their expectations about the future to develop a quantitative projection for each factor. These projections can then be combined to determine a specific update percentage. Finally, the resulting update percentage may be added to any rebasing adjustment determined earlier to produce a consolidated update for the coming year.

Evaluating the current level of payment. Policymakers may examine a broad array of information to evaluate whether the current base payment level is consistent with providers' costs. The direct relevance, availability, cost, and quality of each type of information will

vary by industry and setting:

- **Market prices and costs.** Policymakers could compare Medicare's payment rates directly with market prices and costs for services and products in each setting. Observing market prices and costs often is not feasible, however, because providers' posted fees or charges generally differ from the payments they actually receive from public and private payers. Moreover, measuring actual prices is difficult and extremely costly, partly because they often are determined in private negotiations between individual providers and payers, and neither party wants competitors to know the agreed amounts.
- **Access and quality of care.** Evidence of widespread access or quality problems for beneficiaries might suggest that Medicare's payment rates are too low. In the absence of such evidence, Medicare's rates could be either about right or too high.[18]
- **Entry and exit.** Rapid growth in the number of providers participating in Medicare across many market areas could indicate that Medicare's payment rates are too high. Conversely, widespread provider withdrawals from Medicare could suggest that the rates are too low.
- **Volume growth.** Rapid growth in the volume of services could suggest that Medicare's rates are too high. Declines in volume could indicate the opposite. Either trend, however, also could be explained by changes in technology, beneficiaries' preferences, or practice patterns.
- **Providers' costs, revenues, and margins.** Information on providers' costs and revenues sometimes can be obtained from HCFA's administrative files or from industry surveys. This information often is incomplete because it lacks accurate measures of each provider's overall product mix, and it is available only for some types of providers. As noted earlier, accounting costs may differ from providers' true economic costs. Such cost and revenue data are valuable, however, because they provide a good picture of providers' overall financial condition and financial performance on their Medicare business. Often, these data provide fairly strong evidence about the overall relationship between Medicare's payment rates and providers' Medicare costs for broad sets of services, such as hospital inpatient and outpatient care. They also allow policymakers to track trends in providers' average costs.
- **Changes in the product.** Medicare administrative data and industry surveys also enable policymakers to examine broad trends in the nature of the providers' product. For example, recent declines in hospitals' inpatient costs per discharge partly reflect substantial declines in lengths of stay. Some part of both trends certainly results from ongoing changes in technology (new drugs and improvements in surgical techniques and anesthesia, for instance), but another part reflects a substantial shift in the site of care. More beneficiaries are using post-acute services in rehabilitation facilities, long-term care hospitals, SNFs, or home health care, and they are being discharged to these settings earlier than in the past. The shift in site of care has helped to reduce hospitals' costs per case, but it has not reduced Medicare's per case payment rates. These trends suggest that Medicare's current base payment amount for hospital inpatient care may be too high (see Chapter 3).

In isolation, none of these indicators provides direct evidence about the appropriateness of Medicare's current base payment amounts in any of its payment systems. Collectively, however, they often provide enough evidence for policymakers to make reasonable judgments for at least some settings, such as hospital inpatient care.

Policy objectives and update methods. Once policymakers have decided whether to change the current base payment, they also must decide what factors should be considered in determining the update for the forthcoming year. This decision is driven by their update policy objectives. The objective of maintaining consistency with providers' costs in the next year is common to all update methods. But policymakers also may want to control total program spending.

Historically, differences in update objectives have led policymakers to determine updates using three approaches. One builds the percentage update by examining historical trends and future projections for factors that are expected to affect providers' costs in the forthcoming year. Although some factors may be quantified with reasonable precision, others require substantial judgment. This approach has been used by MedPAC and HCFA in developing update recommendations for most facility-based services, such as hospital inpatient care, SNF services and home health care (see Chapters 3 and 5).

The second approach takes some of the same kinds of factors into account but also considers whether cumulative changes in program spending are likely to be sustainable in light of projected changes in overall economic conditions. This approach, called the sustainable growth rate (SGR) system was adopted in the BBA to set updates for the conversion factor in the physician fee schedule. HCFA annually makes estimates of the update components specified in the law and applies the resulting update to the conversion factor. Technical judgment is required in making these estimates, but there is little room for policymakers' judgment. In this report, the Commission recommends that the Congress consider adopting a somewhat modified form of this approach to set coordinated updates for all ambulatory care payment systems, including those for physician services, hospital outpatient care, ASC services,

18 Issues regarding beneficiaries' access to care and the quality of care will be addressed in the Commission's June report to the Congress.

and various primary care clinics (see Chapter 6).

In the third approach, the update is based only on the projected growth in spending under the traditional fee-for-service program. This projection is used without considering changes in factors that might appropriately affect providers' costs or the affordability of any changes in program spending that might result. HCFA has used this approach in updating county payment rates for Medicare+Choice organizations (see Chapter 2).

Updates based on factors that affect costs. MedPAC and HCFA both use similar conceptual frameworks to arrive at recommendations for updating base payment amounts and cost limits for various facility services. Both frameworks explicitly consider five factors that are expected to affect efficient providers' costs:

- **Projected inflation in input prices.** Input-price inflation generally raises providers' costs, though probably not to the full extent of the rise in prices. Anticipated input-price inflation is indicated by the forecasted increase in an industry-specific (hospitals, for example) national input-price index called a market basket index. A market basket index tracks national average price levels for labor and other inputs, weighted to reflect the relative importance of each input category in the specific industry.
- **Anticipated scientific and technological advances.** This factor is intended to raise Medicare's payment rates to accommodate the expected effects of new technologies that improve quality of care but also increase costs. The idea is to ensure that the payment rates are high enough to allow providers to adopt significant cost-increasing innovations. The size of this factor is a judgment based on literature review and other surveillance methods designed to identify major innovations as they appear.
- **Expected productivity improvements.** This factor reflects the expectation that, in the aggregate, providers should be able to reduce the quantity of inputs required to produce a unit of service while maintaining service quality. Further, the Medicare program should benefit from some portion of this productivity improvement through lower payment rates, just as consumers in private markets do. The size of this downward adjustment is also a judgment. It is often based on analysis of past trends in the specific industry but also considers that the available productivity measures may be inaccurate because they lack adjustments for changes in the quality of care.
- **Site substitution.** This factor is intended to adjust the base payment amount to account for past changes in the product that have altered providers' costs without corresponding changes in Medicare's payment rates. The site substitution factor is a specific instance of the more general rebasing adjustment discussed earlier. Policymakers would apply this adjustment only if they believed that current Medicare payment rates had strayed too far from providers' costs. An adjustment for site substitution has been applied only in developing a consolidated update for hospital inpatient payments. In principle, the adjustment could either lower or raise the base amount. Substitution of post-acute care for hospital inpatient care, for example, may lead policymakers to conclude that the base amount for hospital inpatient payments should be reduced. The same shift, however, might result in an increase in the average severity of SNF patients, which would require more nursing care per day than in the past. Thus, it might be appropriate to raise the base payment amount for SNF services.
- **Case-mix change.** This factor is intended to adjust Medicare's payment rates to reflect the real net change in resource requirements that results from measured and unmeasured changes in the mix of services or products. When the reported (billed) mix of services or cases shifts, the associated relative values ensure that providers' payments rise or fall appropriately. But changes in providers' coding practices could raise relative values and payments with no change in resource use. Conversely, payments would not increase appropriately if patients' average severity levels rose within each product category. This might happen if improvements in technology were to allow healthier patients to receive their care in other settings. The adjustment for case-mix change is intended to raise or lower the payment rates in the forthcoming year to reflect the net effect of this year's changes in coding and within-category severity levels.

Except for input-price inflation, the factors in this framework cannot be estimated with precision. Consequently, the Commission usually identifies a range of potential adjustments for each of the other four factors. The overall update recommendation that results from the framework, thus, is usually stated as a range of reasonable changes in the base payment amount that would keep Medicare's payment rates consistent with providers' costs in the forthcoming year.

This update framework is applied annually, but because judgments are based on both past trends and future projections, update recommendations generally are closely related from year to year. Nevertheless, this approach does not explicitly consider trends in total program spending for each type of service or whether recent spending trends are consistent with anticipated changes in overall economic activity. Consequently, updates based on this framework are not designed to recoup past discrepancies between desired and actual program spending. Instead, these updates are intended to ensure that the payment rates are at the appropriate level in the future.

The sustainable growth rate system. Like the cost-based update approach, the SGR begins with the projected increase in providers' input prices as the base for the annual update. It then adds an update adjustment factor that explicitly considers whether cumulative actual Medicare spending for the specified services is above or below the cumulative level that policymakers believe would be sustainable. If cumulative actual spending exceeds the allowed level, the update is reduced to reestablish projected equality during the forthcoming year. Conversely, if cumulative actual spending is less than the allowed level, the update is increased enough to achieve projected equality. Consequently, updates based on this approach are designed to fully offset past discrepancies in program spending in a single year, if possible.[19] The SGR approach is currently applied only in determining annual updates to the conversion factor in the physician fee schedule, but it could be extended to payments for other services.

To use this method, policymakers must decide how to measure anticipated changes in providers' input prices and what factors to consider in estimating the cumulative level of allowed spending. Anticipated increases in physicians' input prices are measured by a projection of the Medicare economic index (MEI), which tracks changes in physician's earnings, staff salaries, and prices for supplies, equipment, and professional liability insurance.

To determine allowed spending growth, policymakers must identify factors that are likely to cause legitimate changes in Medicare fee-for-service spending for physicians' services and are beyond physicians' control. In addition, they must choose a measure of the nation's capacity to afford increases in spending. Currently, annual allowed spending growth is based on four factors:

- **The percentage change in physicians' input prices.** If the mix and volume of physicians' services remain unchanged, allowed program spending should increase enough to accommodate inflation in input prices for the goods and services physicians purchase to produce care. This factor is measured by the MEI.
- **The percentage change in Medicare Part B enrollment.** Allowed spending should reflect changes in the number of beneficiaries eligible to receive Medicare-covered physicians' services under the traditional fee-for service program.
- **The percentage change in spending that results from changes in law or regulation.** Allowed spending should include the full effects of policy changes enacted in law and implemented in regulations.
- **The percentage change in real gross domestic product (GDP) per capita.** This factor is intended to measure the nation's capacity to afford additional increases in spending that are to some extent within physicians' control. It thus establishes a limit on increases in spending that result from growth in the volume and intensity of services. As long as per capita GDP is growing, however, it allows some increases in spending to accommodate advances in medical science and technology that enhance medical capabilities.

HCFA combines estimates for these four factors to determine a SGR for each year. Allowed spending is estimated by multiplying actual spending in 1997 by the SGRs for the years between then and the current year. Cumulative allowed spending (the sum of allowed spending from 1997 to the current year) is then compared with estimated cumulative actual spending to determine the update adjustment factor that will be applied for the forthcoming year. Finally, the actual update is calculated as the product of the projected change in the MEI and the update adjustment factor.

This approach to update policy is attractive for two reasons. First, it sets some limits on the growth in program spending. Second, by restraining payment rates for services, it may create financial incentives for providers to consider the marginal benefits and costs of providing additional services.

This policy also poses some potential risks. If the update adjustment factors consistently lead to large increases or decreases in the base payment updates over a period of several years, Medicare's payment rates could diverge significantly from providers' costs. This risk is difficult to evaluate because changes in providers' costs are likely to be driven by a range of factors that are unrelated to Medicare's policies. At the same time, however, the potential for divergence under this policy may not be any greater than it would be under the alternative cost-based update approach. Thus, careful monitoring probably should be given a high priority under either update method.

Ensuring payment consistency across settings

In designing a new payment system for specific services or products, policymakers tend to focus their attention narrowly on developing system components that appear to provide the best fit given the nature of the services, patients, and providers in the particular setting. Making these decisions in isolation for each setting, however, may lead to unintended inconsistencies in payment rates across payment systems. These inconsistencies could create inappropriate financial incentives to select one site of care over another in situations where comparable products or services are paid at different rates in two or more settings. Similarly, where either the payment rate or the basis for calculating beneficiary coinsurance differs, beneficiaries could have strong incentives to favor one setting over another.[20]

19 To prevent excessive annual volatility in the payment rates, the update adjustment factor for any year may not be greater than three percentage points or less than minus seven percentage points.

20 Note that this problem differs from the unbundling problem discussed earlier. Even if payment rates for similar services were the same across settings, providers facing a large payment unit would still have incentives to shift some component services to other sites and thereby reduce their costs.

Policymakers' concerns about the potential for inappropriate site selection have increased substantially in recent years. In the past, most facilities were paid on the basis of incurred costs, which obscured payment differentials across settings for individual services and products. But the adoption of prospective payment systems has been making payment differentials increasingly explicit and visible. In addition, as discussed earlier, physicians, hospitals, other facilities, and health plans now are much more likely to be financially interdependent than they were only a decade ago. These financial interrelationships may have increased the likelihood that payment inconsistencies across settings would sometimes lead to inappropriate shifts in the site of care.

Policymakers should be concerned about this problem for two reasons. First, decisions about the site of care should be driven by the patient's clinical needs rather than opportunities for financial gain. Second, when those clinical needs can be met equally in different settings, however, Medicare should not pay more for a service in one setting simply because the providers' costs historically have been higher.

Other factors being equal, Medicare thus should pay the same price for the same service regardless of the setting in which it is furnished. This principle has some implications for payment systems design in settings where providers produce common sets of services. But it also begs the question of when services that look the same might still be paid appropriately at different rates, such as when a service is delivered to patients with substantial differences in health status.

Ambulatory care services

Most ambulatory care services can be provided in a number of settings, such as a physician's office, OPD, or ASC. The Commission's analysis, however, suggests that most types of ambulatory services are provided almost entirely in one setting. In part, this reflects Medicare coverage rules that limit the procedures that may be performed in an ASC. But it also may reflect clinical and economic factors that influence physicians' decisions about the appropriate site of care. Clinical factors may include patient frailty or comorbidities and other risk factors that raise the likelihood that backup services will be needed. Alternatively, many physicians' practices may lack sufficient volume to support ownership of needed equipment or employment of the specialized staff required to perform many imaging or invasive services in the office.

HCFA has not yet implemented its proposed PPS for hospital outpatient services or its revised payment system for ASC services. When these systems are implemented, the payment rates for many services in these settings likely will be higher than the analogous practice expense payments physicians would receive if they performed the same services in the office. These payment differentials might lead to inappropriate shifts in the site of care, away from physicians' offices and toward OPDs and ASCs. The physician's fee schedule payment, however, is largely the same regardless of where a service is provided.[21] Consequently, physicians do not appear to have strong direct financial incentives to shift services among alternative sites of care.

Nevertheless, the potential for inappropriate shifts should not be ignored in designing the OPD and ASC payment systems. Policymakers should build in the capability to compare like services and monitor changes in care settings. This means, at minimum, that like services should be defined in the same way across ambulatory care settings.

Even if services do not shift among ambulatory settings when these payment systems are adopted, it may be appropriate to begin moving toward paying similar rates for the same services across these settings. Moving in this direction raises the question of the circumstances in which services that have the same identifier might appropriately be paid at different rates. One likely possibility is that the same service may have different costs because of differences in patient condition. To explore this possibility, patient characteristics, such as health status differences, should be analyzed for patients who receive the same service within and across these settings. If providers' costs vary in response to differences in patient condition, then specific payment adjustments should be developed to account for such differences. These adjustments should be applied, if possible, at the patient level, rather than the facility level, so that providers are automatically paid appropriately for the mix of patients they actually treat. However, in the absence of the data necessary to identify patients with special needs, a facility-level adjustment may be necessary if such patients are concentrated in certain types of facilities.

Low volume providers in isolated rural communities also may have higher costs for comparable services. If these providers faced the same payment rates that would be appropriate for high volume providers, they might cease providing services, thereby forcing Medicare beneficiaries to travel elsewhere to obtain access to care. This possibility suggests the need to examine cost differences in OPDs and ASCs to see if those located in isolated areas exhibit higher costs. If they do, then it might be appropriate to develop a special payment adjustment, like that for sole community hospitals, which would protect beneficiaries' access to care.

Skilled nursing facilities and rehabilitation hospitals

The principle of payment consistency raises somewhat different issues in the development of a payment system for rehabilitation facilities. Both rehabilitation hospitals (and rehabilitation units of general hospitals) and some SNFs treat patients who need high intensity rehabilitation therapy. Most of these patients, who must be able to

21 The practice expense component is reduced for certain services when they are performed in a hospital or an ASC.

tolerate three hours of intensive therapy per day, are treated in hospital facilities. Some SNFs, however, have developed specialized rehabilitation units to which they admit such patients. Often, these units have been developed because local hospitals do not provide sufficient rehabilitation capacity.

Under the recently implemented SNF prospective payment system, SNFs treating these patients are paid a per diem rate for each day of care. HCFA argues that rehabilitation hospitals also should be paid per diem rates as the first step toward paying the same rate for the same rehabilitation services. Rehabilitation hospitals, however, have been paid under per discharge cost limits for more than 15 years. Moreover, intensive rehabilitation treatment protocols are well defined, and a suitable classification system has been developed for rehabilitation stays.

In choosing the unit of payment for rehabilitation hospitals, policymakers face unattractive trade-offs. The preconditions for payment consistency could be achieved by selecting a per diem unit of payment, matching the SNF payment unit. In a second option, HCFA could adopt the more appropriate per case payment unit. But selecting this option without also changing the recently implemented SNF payment system would sacrifice the potential for payment consistency. In a third option, HCFA could change the recently implemented SNF payment system to adopt the per case payment unit only for intensive rehabilitation patients. HCFA would have to continue using a per diem payment unit for other SNF patients because an effective per stay classification system for all SNF patients does not exist. Elsewhere in this report, the Commission is recommending that HCFA pursue the third option (see Chapter 5).

Considering implementation issues

Implementing new payment systems raises two additional issues that policymakers need to consider. One is that applying a new system will frequently cause a substantial redistribution of payments among providers. To avoid potentially serious disruptions in access to care or quality of care, transition mechanisms often must be developed. These mechanisms are designed to cushion the immediate effects of the new system and allow providers time to adjust to the change in their circumstances.

The second issue concerns the administrative systems and other supporting mechanisms that are needed to operate and maintain a new system over time. The earlier discussion of design issues frequently identifies specific tools and information that are needed to establish the various payment system components. It also describes some of the companion rules and procedures necessary to operate a payment system once it is implemented. Finally, the discussion also highlights the crucial role for monitoring payment system performance, especially beneficiary access to care and the quality of care.

Transition mechanisms

In implementing a new payment system, policymakers must decide whether, and how, to manage the transition from the old payment method to the new one. A transition is more likely to be needed when the potential effects on individual providers' payments may be large, or when policymakers are highly uncertain about providers' responses to the new system. At the same time, program savings anticipated from the new payment system generally would be reduced by any transition method, although the loss of savings may be greater with some methods than it would be with others. Likewise, any improvement in providers' incentives generally would be weakened by any transition method.

Choices among transition methods often involve trade-offs between establishing absolute limits on the percentage change in any provider's payments and the administrative burden for HCFA and providers. Alternative methods also may affect providers' payment incentives in somewhat different ways.

Several transition methods have been used in implementing new payment systems:

- hold-harmless and minimum increase methods, which ensure that each provider's payments under the new system would be at least equal to its base year payments or a specified percentage above those payments,
- corridor limits on the percentage change in payments, which ensure that a provider's payments would neither decrease nor increase by more than the specified percentage each year, and
- a blend approach, which mixes payment amounts under the old system with those under the new one in specified proportions that change each year.

Supporting administrative systems

All payment systems require a substantial supporting infrastructure. This administrative infrastructure performs a variety of functions, such as defining covered services, identifying which providers may furnish specific types of services, and ensuring the availability of data needed to establish and maintain the payment rates and related factors.

Coverage policies may play an especially important role in settings where the product is not well defined, consensus about the medical necessity of services is weak, physician oversight or involvement is limited, or there is a large potential for shifts in the site of care. One reason that home care episodes are difficult to define, for example, is that the related coverage policies are vague or ill-defined. Coverage policies limiting the procedures that may be performed in an ASC, however, may have prevented

some appropriate as well as inappropriate shifts in services from OPDs to ASCs.

Smoothly functioning data systems are essential because most components of a payment system are data driven. The payment amounts, relative values, and other payment adjustments often can be updated based on analyses of provider cost, claims, and spending data drawn from standard administrative files. But special studies based on other data sources also are needed periodically to provide information about specific payment or update components for some settings or services. For instance, information about staff time use for the relative values in the SNF payment system must be collected in special surveys.

As a tool for achieving Medicare's overall goals, payment policy has limits. Payment policy alone cannot simultaneously ensure that the production and distribution of health care services is efficient and that beneficiaries have appropriate access to high quality care. Other administrative systems are needed to help reach these goals, such as access and quality monitoring systems. Although data and monitoring systems are reasonably well developed for hospital inpatient care, similar systems are much less fully developed for ambulatory and post-acute care services, where they are arguably more essential.

The need for this supporting infrastructure inevitably raises issues about the appropriate level of funding for the many administrative activities carried out by HCFA and its private contractors. In addition, the number and complexity of decisions required to maintain and coordinate many payment systems in a rapidly changing environment suggests that HCFA needs a substantial amount of flexibility to fashion appropriate and timely changes in policy and meet its obligations to beneficiaries and taxpayers. MedPAC endorses the views recently expressed on these topics in an open letter published in the journal *Health Affairs*.

Open Letter to Congress & the Executive

Crisis Facing HCFA & Millions Of Americans The signatories to this statement believe that many of the difficulties that threaten to cripple the Health Care Financing Administration (HCFA) stem from an unwillingness of both Congress and the Clinton administration to provide the agency the resources and administrative flexibility necessary to carry out its mammoth assignment. This is not a partisan issue, because both Democrats and Republicans are culpable for the failure to equip HCFA with the human and financial resources it needs to address what threatens to become a management crisis for the agency and thus for millions of Americans who rely on it. This is also not an endorsement of the present or past administrative activities of the agency. Congress and the administration should insist on an agency that operates efficiently and in the public interest.

Over the past decade Congress has directed the agency to implement, administer, and regulate an increasing number of programs that derive from highly complex legislation. While vast new responsibilities have been added to its heavy workload, some of its most capable administrative talent has departed or retired; other employees have been reassigned as a consequence of reductions in force. At the same time, neither Democratic nor Republican administrations have requested administrative budgets of a size that were in any way commensurate with HCFA's growing challenge.

The latest report of the Medicare trustees points out that HCFA's administrative expenses represented only 1 percent of the outlays of the Hospital Insurance trust fund and less than 2 percent of the Supplementary Medical Insurance trust fund. In part, these low percentages reflect the rapid growth of the denominator—Medicare expenditures. But, even accounting for Medicare's growth, no private health insurer, after subtracting its marketing costs and profit, would ever attempt to manage such large and complex insurance programs with so small an administrative budget. Without prompt attention to these issues, HCFA will fall further behind in its implementation of the many significant reforms mandated by the Balanced Budget Act (BBA) of 1997. In the future the agency also has to cope with a demographic revolution that it is ill equipped to accommodate and with changes in medical technology that will increase fiscal pressures on the programs it administers.

As the Bipartisan Commission on the Future of Medicare grapples with the problem of reshaping the Medicare program for the next millennium, it would do well to consider two important reforms concerning HCFA's administration. First, the commission should recommend that Congress and the Clinton administration endow the agency with an administrative capacity that is similar to that found in the private sector. Second, the commission should consider ways in which the micromanagement of the agency by Congress and the Office of Management and Budget could be reduced. Congress and the public would be better served by measuring the agency's efficiency in terms of its administrative outcomes (such as accuracy and speed of reimbursement of various providers), rather than by tightly controlling its administrative processes. Only if HCFA has more

continued on page 22

Open Letter to Congress & the Executive

continued from p. 21

administrative resources and greater management flexibility will it be able to cope with the challenges that lie ahead.

The mismatch between the agency's administrative capacity and its political mandate has grown enormously over the 1990s. As the number of beneficiaries, claims, and participating provider organizations; quality and utilization review; and oversight responsibilities have increased geometrically, HCFA has been downsized. When HCFA was created in 1977, Medicare spending totaled $21.5 billion, the number of beneficiaries served was twenty-six million, and the agency had a staff of about 4,000 full-time-equivalent workers. By 1997 Medicare spending had increased almost tenfold to $207 billion, the number of beneficiaries served had grown to thirty-nine million, but the agency's workforce was actually smaller than it had been two decades earlier. The sheer technical complexity of its new policy directives is mind-boggling and requires a new generation of employees with the requisite skills.

HCFA's ability to provide assistance to beneficiaries, monitor the quality of provider services, and protect against fraud and abuse has been increasingly compromised by the failure to provide the agency with adequate administrative resources. Even with the addition of $154 million to its administrative budget that Congress included in its latest budget bill, the likelihood that HCFA can effectively implement all of its varied assignments is remote. The Health Insurance Portability and Accountability Act of 1996 assigns many new regulatory responsibilities to HCFA, but a far larger task is implementing the BBA of 1997. The BBA has more than 300 provisions affecting HCFA programs, including the Medicare+Choice option, which will require complex institutional changes and ambitious efforts to educate beneficiaries.

Medicare spending accounts for more than 11 percent of the U.S. budget. Workable, effective administration has to be a primary consideration in any restructuring proposal. Whether Medicare reform centers on improving the current system, designing a system that relies on market forces to promote efficiency through competition, or moving toward an even more individualized approach to paying for health insurance, Congress and the administration must reexamine the organization, funding, management, and oversight of the Medicare program. Doing anything less is short-changing the public and leaving HCFA in a state of disrepair.

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Conclusions

The primary goal of Medicare's payment policies should be to help beneficiaries obtain medically necessary acute care of reasonable quality in the most appropriate clinical setting. At some level, this goal is the ultimate touchstone for all program policies. It is especially important for payment policies, however, because of their power to affect providers' willingness and ability to furnish good care. Therefore, when policymakers are designing or evaluating a payment system, they should repeatedly ask how it will work for all beneficiaries and especially for those who are vulnerable because of their circumstances.

To avoid serious problems for beneficiaries or taxpayers and promote efficient production and distribution of acute care services, Medicare's payment rates must be consistent with providers' costs. But Medicare buys a wide range of health care products furnished in a variety of settings by different types of providers who must compete for scarce resources in local private markets. Consequently, Medicare's payment systems must appropriately account for:

- the types of products Medicare is buying,
- the clinical and economic factors, including differences among patients, that account for legitimate variation in costs among products, types of providers or settings for care, and local markets, and
- the factors that are likely to cause appropriate changes in costs over time.

Successfully setting and maintaining payment rates consistent with providers' costs in many provider-specific payment systems thus raises a host of practical and policy questions that must be answered to make decisions about units of payment,

product definitions and relative values, and other payment system components.

What is Medicare buying in a particular setting?

- What are the clinical components of the care provided?
- What are the clinical factors that distinguish among types of services, patients, or beneficiaries?
- What services are included in each type of product?

What factors account for predictable variation in the cost of producing these products?

- What does the provider's production process look like?
- What are the components of costs?
- What factors account for predictable cost variation among types of services, patients, or beneficiaries?
- What factors account for regional or local cost variation?
- What special circumstances should be taken into account to protect access to care?

How should we determine the level of payment?

- Providers' historical costs?
- Anticipated program spending?

How would we know if payment rates were too high or too low?

- Provider entry or exit?
- Rapid changes in volume?
- Widespread access or quality problems?
- Providers' financial condition?

What factors should be considered in adjusting the payment rates over time?

- Anticipated changes in factors that affect providers' unit costs?
- Growth in program spending compared with that of the overall economy?

Are similar services or products available in another setting?

- What is the extent of the overlap?
- Who chooses the site of care and what incentives do they face?

Under what circumstances should Medicare pay more for a service in one setting than in another?

- Differences in patient condition?
- Unusual market conditions?

Empirical analysis can illuminate many of these questions, depending on available data. All of the policy questions, however, inevitably involve making trade-offs between potentially desirable and undesirable outcomes. Moreover, balancing these trade-offs is often complicated by two factors. One is uncertainty about the extent of providers' opportunity and inclination to respond to payment incentives in undesirable ways. The other is the lack of tools and information needed to develop payment adjustments that would focus payment more appropriately on the patient and the service rather than the provider or setting in which it is furnished.

Nevertheless, trade-offs must be evaluated and design choices must be made in the short term. In this regard, the Commission's policy framework may prove especially useful in explicitly highlighting the gains and sacrifices associated with specific choices as well as alternatives that should be pursued in the future. ■

References

Pauly MV. Doctors and their workshops: economic models of physician behavior. Chicago, The University of Chicago Press. 1980.

Prospective Payment Assessment Commission. Report to the Congress: Medicare and the American health care system. Washington (DC), ProPAC. June 1997.