

CHAPTER

2

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

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Chapter summary

As required by law, the Commission annually makes payment update recommendations for providers paid under fee-for-service (FFS) Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. To determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2019) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year, 2020). As part of the process, we examine payments to support the efficient delivery of services, consistent with our statutory mandate. Finally, we make a judgment about what, if any, update is needed. (The Commission also assesses Medicare payment systems for Part C and Part D and makes recommendations as appropriate. But because they are not FFS payment systems, they are not part of the discussion in this chapter.)

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professionals, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health care agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospices. Each year, the Commission looks at all available indicators of

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payment adequacy and reevaluates any assumptions from prior years, using the most recent data available to make sure its recommendations accurately reflect current conditions. We may also consider recommending changes that redistribute payments within a payment system to correct any biases that may make treating patients with certain conditions financially undesirable, make particular procedures unusually profitable, or otherwise result in inequity among providers. Finally, we may also make recommendations to improve program integrity.

Our recommendations, if enacted, could significantly change the revenues providers receive from Medicare. Rates set to cover the costs of relatively efficient providers help create fiscal pressure on all providers to control their costs. Medicare rates also have broader implications for health care spending. For example, Medicare rates are commonly used to set hospital rates charged to uninsured patients eligible for financial assistance, used by Medicare Advantage plans to set hospital prices, and used by the Department of Veterans Affairs (VA) to pay non-VA providers (Department of Veterans Affairs 2010, Internal Revenue Service 2014, Medicare Payment Advisory Commission 2013).

The Commission also examines payment rates for services that can be provided in multiple settings. Medicare often pays different amounts for similar services across settings. Basing the payment on the rate in the most efficient setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the financial incentive to provide services in the higher paid setting. However, putting into practice the principle of paying the same rate for the same service across settings can be complex because it requires that the definition of the services and the characteristics of the beneficiaries be sufficiently similar across settings. In March 2012, we recommended equalizing rates for evaluation and management office visits provided in hospital outpatient departments and physicians' offices (Medicare Payment Advisory Commission 2012). In 2014, we extended that recommendation to additional services provided in those two settings and recommended consistent payment between acute care hospitals and long-term care hospitals for certain classes of patients (Medicare Payment Advisory Commission 2014). In the Bipartisan Budget Act of 2015, the Congress made payment to outpatient departments for certain services equal to the physician fee schedule rates for those same services provided at any new outpatient off-campus location beginning in 2018.

In 2016, to make payments across all of the post-acute care payment settings comparable, the Commission recommended elements of a single prospective payment system (PPS) for all post-acute care to replace the four independent PPSs

in use today (the skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, and home health PPSs) (Medicare Payment Advisory Commission 2016). Most recently, in 2018, we recommended blending setting-specific and unified post-acute care PPS relative weights to help transition to a unified system (Medicare Payment Advisory Commission 2018). The Commission will continue to analyze opportunities for applying this principle to other services and settings. ■

Background

The goal of Medicare payment policy should be to obtain good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums. Steps toward this goal involve:

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

To help determine the appropriate base payment rate for a given payment system in 2020, we first consider whether payments are adequate for relatively efficient providers in 2019. To inform the Commission's judgment, we examine the most recent available data on beneficiaries' access to care, the quality of care, and providers' access to capital, as well as projected Medicare payments and providers' costs for 2019. We then consider how providers' costs will change in 2020. Taking these factors into account, we recommend how Medicare payments for the sector in aggregate should change in 2020.

Within a given level of funding for a sector, we may also consider changes in payment policy to improve relative payment accuracy across patients and procedures. Such changes are intended to improve equity among providers or access to care for beneficiaries and may also affect the distribution of payments among providers in a sector. For example, in 2018, the Commission recommended that CMS use a blend of the setting-specific relative weights and the unified post-acute care (PAC)–prospective payment system (PPS) relative weights for each of the four PAC settings to redistribute payments within each setting toward medically complex patients (Medicare Payment Advisory Commission 2018).

We also make recommendations to improve program integrity when needed. In some cases, our data analysis reveals problematic variation in service utilization across

geographic regions or providers. For example, in reaction to patterns of unusually long stays in a subset of hospices, we recommended medical review focused on hospices that have many long-stay patients. In 2016, we recommended the Secretary closely examine the coding practices of certain inpatient rehabilitation facilities that appear to result in very high Medicare margins.

We compare our recommendations for updates and other policy changes for 2020 with the base payment rates specified in law to understand the implications for beneficiaries, providers, and the Medicare program. As has been the Commission's policy in the past, we consider our recommendations each year in light of the most current data and, in general, recommend updates for a single year.

Are Medicare payments adequate in 2019?

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

- beneficiaries' access to care
- quality of care
- providers' access to capital
- Medicare payments and providers' costs for 2019

Some measures focus on beneficiaries (e.g., access to care) and some focus on providers (e.g., the relationship between payments and costs). The direct relevance, availability, and quality of each type of information vary among sectors, and no single measure provides all the information needed for the Commission to judge payment adequacy. Ultimately, the Commission makes its recommendations considering all of these factors.

Beneficiaries' access to care

Access to care is an important indicator of the willingness of providers to serve Medicare beneficiaries and the adequacy of Medicare payments. For example, poor access could indicate that Medicare payments are too low. However, factors unrelated to Medicare's payment policies may also affect access to care. These factors include coverage policies, beneficiaries' preferences, local market conditions, and supplemental insurance.

The measures we use to assess beneficiaries' access to care depend on the availability and relevance of information in each sector. We use results from several surveys to assess the willingness of physicians and other health professionals to serve beneficiaries and beneficiaries' opinions about their access to physician and other health professional services. For home health services, we examine data on whether communities are served by providers.

Access: Capacity and supply of providers

Rapid growth in the capacity of providers to furnish care may increase beneficiaries' access and indicate that payments are more than adequate to cover providers' costs. Changes in technology and practice patterns may also affect providers' capacity. For example, less invasive procedures could be performed in outpatient settings, and lower priced equipment could be more easily purchased by providers, increasing the capacity to provide certain services.

Substantial increases in the number of providers may suggest that payments are more than adequate and could raise concerns about the value of the services being furnished. If Medicare is not the dominant payer for a given provider type (such as ambulatory surgical centers), changes in the number of providers may be influenced more by other payers and their demand for services and thus may be difficult to relate to Medicare payments. When facilities close, we try to distinguish between closures that have serious implications for access to care in a community and those that may have resulted from excess capacity. For example, in 2016, Medicare's payment rates for certain cases in long-term care hospitals (LTCHs) decreased significantly, and about 40 LTCHs closed—nearly 10 percent of LTCH facilities and beds. However, the closures primarily occurred in market areas with multiple LTCHs, and overall LTCH occupancy declined during the same time period—indicating adequate capacity.

Access: Volume of services

The volume of services can be an indirect indicator of beneficiary access to services. An increase in volume shows that beneficiaries are receiving more services and suggests sufficient access—although it does not necessarily demonstrate that the services are appropriate. Volume is also an indicator of payment adequacy; an increase in volume beyond what would be expected relative to the increase in the number of beneficiaries could suggest that Medicare's payment rates are too high. Very rapid increases in the volume of a service might even raise

questions about program integrity or whether the definition of the corresponding benefit is too vague. Reductions in the volume of services can sometimes be a signal that revenues are inadequate for providers to continue operating or to provide the same level of service. Finally, rapid changes in volume between sectors whose services can be substituted for one another may suggest distortions in payment and raise questions about provider equity. For example, payment rates for evaluation and management (E&M) office visits are much higher in hospital outpatient departments (HOPDs) than in physicians' offices, and over the last several years, the volume of those services in HOPDs has increased while the volume in physicians' offices has decreased.

However, changes in the volume of services are not direct indicators of access; increases and decreases can be explained by other factors such as population changes, changes in disease prevalence among beneficiaries, technology, practice patterns, deliberate policy interventions, and beneficiaries' preferences. For example, the number of Medicare beneficiaries in the traditional fee-for-service (FFS) program varies from year to year; therefore, we look at the volume of services per FFS beneficiary as well as the total volume of services. Explicit policy decisions can also influence volume. For example, during fiscal year 2016, CMS began phasing in a policy that lowers payments for certain LTCH cases. As a result, LTCHs—as expected—changed their admitting practices largely in response to the implementation of the policy, and the number of LTCH discharges decreased markedly.

Changes in the volume of physician services must be interpreted particularly cautiously. Evidence suggests that for discretionary services, volume may go up when payment rates go down—the so-called volume offset. Whether a volume offset phenomenon exists in other sectors depends on how discretionary the services are and on the ability of providers to influence beneficiaries' demand for them.

Access: Marginal profit

Another factor we consider when evaluating access to care is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (e.g., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an

additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries. We note, however, that in instances in which a sector does not have substantial excess capacity or in which Medicare composes a dominant share of a sector's patients, marginal profit may be a less useful indicator of access to care.

Quality of care

The relationship between the quality of care and the adequacy of Medicare payment is not direct. Simply increasing payments through an update for all providers in a sector, regardless of their individual quality, is unlikely to influence the quality of care because, historically, Medicare payment systems have created little or no incentive for providers to spend additional resources on improving quality.

The Medicare program has begun to implement quality-based payment policies in a number of sectors; however, some issues have arisen. First, it is very difficult to differentiate quality performance among providers when the number of cases per provider is low. This issue has been particularly vexing in measuring quality performance for individual clinicians. Second, the Commission has been increasingly concerned that Medicare's approach to quality measurement is flawed because it relies on too many clinical process measures. Many current process measures are weakly correlated with outcomes of interest such as mortality and readmissions, and most process measures focus on addressing the underuse of services, while the Commission believes that overuse and inappropriate use are also of concern. Third, reliance on provider-reported measures can create a burden on providers and can lead to biased reporting in response to strong financial incentives. As an example of the latter, since 2014, home health agencies reported improvements in provider-reported measures such as transferring and walking, even though more objective, claims-based outcome measures (such as the use of emergency department care and hospital admissions) have not improved or have worsened.

As an alternative approach, we have begun exploring the use of a small set of population-based outcome measures to assess and compare the performance of FFS Medicare, Medicare Advantage, and Medicare accountable care organizations within a local area. For example, in Chapter 15, we discuss a small set of outcome, patient experience,

and cost measures for use in a hospital value incentive program (HVIP).

Providers' access to capital

Providers must have access to capital to maintain and modernize their facilities and to improve their capability to deliver patient care. Widespread ability to access capital throughout a sector may reflect the adequacy of Medicare payments. Some sectors such as hospitals require large capital investments, and access to capital can be a useful indicator. Other sectors such as home health care do not need large capital investments, so access to capital is a more limited indicator. In some cases, a broader measure such as changes in employment may be a useful indicator of financial health within a sector. Similarly, in sectors where providers derive most of their payments from other payers (such as ambulatory surgical centers) or other lines of business, or when conditions in the credit markets are extreme, access to capital may be a limited indicator of the adequacy of Medicare payments.

One indicator of a sector's access to capital is its all-payer profitability reflecting income from all sources. We refer to this amount as the sector's total margin, which is calculated as aggregate income, minus costs, divided by income. Total margins can inform our assessment of a sector's overall financial condition and hence its access to capital.

Medicare payments and providers' costs for 2019

For most payment sectors, we estimate Medicare payments and providers' costs for 2019 to inform our update recommendations for 2020. To maintain Medicare beneficiaries' access to high-quality care while keeping financial pressure on providers to make better use of taxpayers' and beneficiaries' resources, we investigate whether payments are adequate to cover the costs of relatively efficient providers, where available data permit such providers to be defined.

Relatively efficient providers use fewer inputs to produce quality outputs. Efficiency could be increased by using the same inputs to produce a higher quality output or by using fewer inputs to produce the same quality output. The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well on cost and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric over the past three

years. The Commission’s approach is to develop a set of criteria and then examine how many providers meet those criteria. It does not establish a set share of providers to be considered efficient and then define criteria to meet that pool size.

For providers that submit cost reports to CMS—acute care hospitals, skilled nursing facilities (SNFs), home health agencies, outpatient dialysis facilities, inpatient rehabilitation facilities (IRFs), LTCHs, and hospices—we estimate total Medicare-allowable costs and assess the relationship between Medicare’s payments and those costs. We typically express the relationship between payments and costs as a payment margin, which is calculated as aggregate Medicare payments for a sector, minus costs, divided by payments. By this measure, if costs increase faster than payments, margins will decrease.

In general, to estimate payments, we first apply the annual payment updates specified in law for 2018 and 2019 to our base data (2017 for most sectors). We then model the effects of other policy changes that will affect the level of payments in 2019. To estimate 2019 costs, we consider the rate of input price inflation or historical cost growth, and, as appropriate, we adjust for changes in the product (such as fewer visits per episode of home health care) and trends in key indicators (such as historical cost growth and the distribution of cost growth among providers).

Use of margins

In most cases, we assess Medicare margins for the services furnished in a single sector and covered by a specific payment system (e.g., SNF or home health services). However, in the case of hospitals, which often provide services that are paid for by multiple Medicare payment systems, our measures of payments and costs for an individual sector could become distorted because of the allocation of overhead costs or the presence of complementary services. For example, having a hospital-based SNF or IRF may allow a hospital to achieve shorter lengths of stay in its acute care units, thereby decreasing costs and increasing inpatient margins. For hospitals, we assess the adequacy of payments for the whole range of Medicare services they furnish—inpatient and outpatient (which together account for more than 90 percent of Medicare payments to hospitals), SNF, home health, psychiatric, and rehabilitation services—and compute an overall Medicare hospital margin encompassing costs and payments for all the sectors. The hospital update recommendation in Chapter 3 applies to hospital

inpatient and outpatient payments; the updates for other distinct units of the hospital, such as SNFs, are covered in separate chapters.

The adequacy of Medicare payments is assessed relative to the costs of treating Medicare beneficiaries, and the Commission’s recommendations address a sector’s Medicare payments, not total payments. We calculate a sector’s Medicare margin to determine whether total Medicare payments cover average providers’ costs for treating Medicare patients and to inform our judgment about payment adequacy. Margins will always be distributed around the average, and aggregate payment adequacy does not mean that every provider has a positive Medicare margin. To assess whether changes are needed in the distribution of payments, we calculate Medicare margins for certain subgroups of providers with unique roles in the health care system. For example, because location and teaching status enter into the payment formula, we calculate Medicare margins based on where hospitals are located (in urban or rural areas) and their teaching status (major teaching, other teaching, or nonteaching).

Multiple factors can contribute to changes in the Medicare margin, including changes in the efficiency of providers, changes in coding that may change case-mix adjustment, and other changes in the product (e.g., reduced lengths of stay at inpatient hospitals). Knowing whether these factors have contributed to margin changes may inform decisions about whether and how much to change payments.

In sectors where the data are available, the Commission makes a judgment when assessing the adequacy of payments relative to costs. No single standard governs this relationship for all sectors, and margins are only one indicator for determining payment adequacy. Moreover, although payments can be ascertained with some accuracy, there may be no “true” value for reported costs, which reflect accounting choices made by providers (such as allocations of costs to different services) and the relationship of service volume to capacity in a given year. Further, even if costs are accurately reported, they reflect strategic investment decisions of individual providers, and Medicare—as a prudent payer—may choose not to recognize some of these costs or may exert financial pressure on providers to encourage them to reduce their costs.

Appropriateness of current costs

Our assessment of the relationship between Medicare’s payments and providers’ costs is complicated by differences in providers’ efficiency, responses to changes

in payment systems, product changes, and cost reporting accuracy. Measuring the appropriateness of costs is particularly difficult in new payment systems because changes in response to the incentives in the new system are to be expected. For example, the number and types of visits in a home health episode changed significantly after the home health PPS was introduced, although the payments were based on the older, higher level of use and costs. In other systems, coding may change. As an example, the hospital inpatient PPS introduced a new patient classification system in 2008 to improve payment accuracy. However, for a number of years after its implementation, it resulted in higher payments because provider coding became more detailed, making patient complexity appear higher—although the underlying patient complexity was largely unchanged. Any kind of rapid change in policy, technology, or product can make it difficult to measure costs per unit.

To assess whether reported costs reflect the costs of efficient providers, we examine recent trends in the average cost per unit, variation in standardized costs and cost growth, and evidence of change in the product. One issue Medicare faces is the extent to which private payers exert pressure on providers to constrain costs. If private payers do not exert pressure, providers' costs will increase and, all other things being equal, margins on Medicare patients will decrease. Providers who are under pressure to constrain costs generally have managed to slow their growth in costs more than those who face less pressure (Medicare Payment Advisory Commission 2011, Robinson 2011, White and Wu 2014). Some have suggested that, in the hospital sector, costs are largely outside the control of hospitals and that hospitals shift costs onto private insurers to offset Medicare losses. This belief assumes that costs are immutable and not influenced by whether the hospital is under financial pressure. We find that costs do vary in response to financial pressure and that low margins on Medicare patients can result from a high cost structure that has developed in reaction to high private-payer rates. In other words, when providers (particularly not-for-profit providers) receive high payment rates from insurers, they face less pressure to keep their costs low, and so, all other things being equal, their Medicare margins are low because their costs are high. (For-profit providers may prefer to keep costs low to maximize returns to stockholders and, indeed, often have higher Medicare margins than similar nonprofit providers.) Lack of pressure is more common in markets where a few providers dominate and have negotiating leverage over

payers. In some sectors, Medicare itself could, and should, exert greater pressure on providers to reduce costs.

Variation in cost growth among a sector's providers can give us insight into the range of performance that facilities can achieve. For example, if some providers' costs grow more rapidly than others in a given sector, we might question whether those rapid increases are appropriate. Changes in product can also significantly affect unit costs. Returning to the example of home health services, one would expect that substantial reductions in the number of visits per 60-day home health episode would reduce costs per episode. If costs per episode instead were to increase while the number of visits were to decrease, one would question the appropriateness of the cost growth and not increase Medicare payments in response.

In summary, Medicare payment policy should not be designed simply to accommodate whatever level of cost growth a sector demonstrates. Cost growth can oscillate from year to year depending on factors such as economic conditions and relative market power. Payment policy should accommodate cost growth only after taking into account a broad set of payment adequacy indicators, including the current level of Medicare payments.

What cost changes are expected in 2020?

The second part of the Commission's approach to developing payment update recommendations is to consider anticipated policy and cost changes in the next payment year. For each sector, we review evidence about the factors that are expected to affect providers' costs. One factor is the change in input prices, as measured by the price index that CMS uses for that sector. (These indexes are estimated quarterly; we use the most recent estimate available when we do our analyses.) For facility providers, we start with the forecasted increase in an industry-specific index of national input prices, called a "market basket index." For physician services, we start with a CMS-derived weighted average of price changes for inputs used to provide physician services. Forecasts of these indexes approximate how much providers' costs would change in the coming year if the quality and mix of inputs they use to furnish care remained constant—that is, if there were no change in efficiency. Other factors may include the trend in actual cost growth, which could be

used to inform our estimate if it differs significantly from the projected market basket.

How should Medicare payments change in 2020?

The Commission's judgments about payment adequacy, forthcoming policy changes, and expected cost changes result in an update recommendation for each payment system. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. In considering updates, the Commission makes its recommendations for 2020 relative to the 2019 base payment as defined in Medicare's authorizing statute—Title XVIII of the Social Security Act. The Commission's recommendations may call for an increase, a decrease, or no change from the 2019 base payment. For example, if the statutory base payment for a sector were \$100 in 2019, an update recommendation of a 1 percent increase for a sector means that we are recommending that the base payment in 2020 for that sector be 1 percent greater, or \$101.

When our recommendations differ from current law, as they often do, the Congress and the Secretary of Health and Human Services would have to take action and change law or regulation to put them into effect. Each year, we look at all available indicators of payment adequacy and reevaluate prior-year assumptions using the most recent data available. The Commission does not start with any presumption that an update is needed or that any increase in costs should be automatically offset by a payment update. Instead, an update (which may be positive, zero, or negative) is warranted only if it is supported by the empirical data, in the judgment of the Commission.

In conjunction with the update recommendations, we may also make recommendations to improve payment accuracy that might in turn affect the distribution of payments among providers. These distributional changes are sometimes, but not always, budget neutral. Our recommendation to shift payment weights from therapy to medically complex PAC cases is one example of a distributional change that would affect providers differentially based on their patients' characteristics.

The Commission, as it makes its update recommendations, may in some cases take into consideration payment differentials across sectors and make sure the relative update recommendations for the sectors do not exacerbate

existing incentives to choose a site of care based on payment considerations. The difficulty of harmonizing payments across sectors to remove inappropriate incentives illustrates one weakness of FFS payment systems specific to each provider type and highlights the importance of moving beyond FFS to more global and patient-centric payment systems. As we continue to support moving Medicare payment systems toward those approaches, we will also continue to look for opportunities to rationalize payments for specific services across sectors to approximate paying the costs of the most efficient sector and lessen financial incentives to prefer one sector over another. Our June 2016 report on a unified PAC PPS addressed these issues directly (Medicare Payment Advisory Commission 2016).

Consistent payment for the same service across settings

A beneficiary can sometimes receive a similar service in different settings. Depending on which setting the beneficiary or the treating clinician chooses, Medicare and the beneficiary may pay different amounts. For example, when leaving the hospital, patients with joint replacements requiring physical therapy might be discharged with home health care or outpatient therapy, or they might be discharged to a SNF or IRF, and Medicare payments (and beneficiary cost sharing) can differ widely as a result.

A core principle guiding the Commission is that Medicare should pay the same amount for the same service, even when it is provided in different settings. Putting this principle into practice requires that the definition of services in the settings and the characteristics of the patients be sufficiently similar. Where these conditions are not met, offsetting adjustments would have to be made to ensure comparability. Because Medicare's payment systems were developed independently and have had different update trajectories, payments for similar services can vary widely. Such differences create opportunities for Medicare and beneficiary savings if payment is set at the level applicable to the lowest priced setting in which the service can be safely performed. For example, under the current payment systems, a beneficiary can receive the same physician visit service in a hospital outpatient clinic or in a physician's office. In fact, the same physician could see the same patient and provide the same service, but depending on whether the service is provided in an outpatient clinic or in a physician's office, Medicare's payment and the beneficiary's coinsurance can differ by 80 percent or more.

In 2012, the Commission recommended that payments for E&M office visits in the outpatient and physician office sectors be made equal. This service is comparable across the two settings. Our recommendation sets payment rates for E&M office visits both in the outpatient department and physician office sectors equal to those in the physician fee schedule, lowering both program spending and beneficiary liability (Medicare Payment Advisory Commission 2012). In 2014, we extended that principle to additional services for which payment rates in the outpatient PPS should be lowered to better match payment rates in the physician office setting (Medicare Payment Advisory Commission 2014). In the Bipartisan Budget Act of 2015, the Congress made payment for outpatient departments for the same services equal to the physician fee schedule rates for those services at any new outpatient off-campus clinic beginning in 2018. We also recommended consistent payment between acute care hospitals and long-term care hospitals for certain categories of patients (Medicare Payment Advisory Commission 2014). In 2016, we recommended elements of a unified PAC PPS that would make payments based on patients' needs and characteristics, generally irrespective of the PAC entity that provided their care (Medicare Payment Advisory Commission 2016). The Commission will continue to study other services that are provided in multiple sites of care to find additional services for which the principle of the same payment for the same service can be applied.

Budgetary consequences

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Commission to consider the budgetary consequences of our recommendations. Therefore, this report documents how spending for each recommendation would compare with expected spending under current law. We also assess the effects of our recommendations on beneficiaries and providers. Although we recognize budgetary consequences, our recommendations are not driven by any specific budget target but, instead, reflect our assessment of the level of payment needed to provide adequate access to appropriate care.

Payment adequacy in context

As discussed in Chapter 1, it is essential to look at payment adequacy not only within the context of individual payment systems but also in terms of Medicare

as a whole. The Commission is concerned by any increase in Medicare spending per beneficiary without a commensurate increase in value such as higher quality of care or improved health status. Growth in spending per beneficiary, combined with the aging of the baby boomers, will result in the Medicare program absorbing increasing shares of the gross domestic product and federal spending. Medicare's rising costs are projected to exhaust the Hospital Insurance Trust Fund (which funds Medicare Part A) and significantly burden taxpayers. Ensuring that the recent moderate growth trends in Medicare spending per beneficiary continue will require vigilance. The financial future of Medicare prompts us to look at payment policy and ask what can be done to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity.

In many past reports, the Commission has stated that Medicare should institute policies that improve the program's value to beneficiaries and taxpayers. CMS is beginning to take such steps, and we discuss them in the sector-specific chapters that follow. Ultimately, increasing Medicare's value to beneficiaries and taxpayers requires knowledge about the costs and health outcomes of services. Until more information about the comparative effectiveness of new and existing health care treatments and technologies is available, patients, providers, and the program will have difficulty determining what constitutes high-quality care and effective use of resources.

As we examine each of the payment systems, we also look for opportunities to develop policies that create incentives for providing high-quality care efficiently across providers and over time. Some of the current payment systems create strong incentives for increasing volume, and very few of these systems encourage providers to work together toward common goals. Alternative payment models (e.g., the Next Generation accountable care organization model) are meant to stimulate delivery system reform toward more integrated and value-oriented health care systems and may address these issues. In the near term, the Commission will continue to closely examine a broad set of indicators, make sure there is consistent pressure on providers to control their costs, and set a demanding standard for determining which sectors qualify for a payment update each year. In the longer term, pressure on providers may cause them to increase their participation in alternative payment models. We will continue to contribute to the development of those models and to increase their efficacy. ■

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