

CHAPTER

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

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

## Chapter summary

As required by law, the Commission annually makes payment update recommendations for providers paid under Medicare’s traditional fee-for-service (FFS) payment systems. 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 (2021) by considering beneficiaries’ access to care, the quality of care, providers’ access to capital, and how Medicare payments compare with providers’ costs. As part of that process, we examine whether payments will support the efficient delivery of services, consistent with our statutory mandate. Next, we assess how those providers’ costs are likely to change in the year the update will take effect (the policy year; here, 2022). Finally, we make a judgment about what, if any, update is needed for the policy year in question. (The Commission also assesses Medicare payment systems for Part C (Medicare Advantage) and Part D (outpatient prescription drug coverage) in this report and makes recommendations as appropriate. But because they are not FFS payment systems, they are not discussed in this chapter.)

To the extent that events create temporary shocks to the Medicare component of providers’ finances, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers’ Medicare

## In this chapter

- Are Medicare payments adequate in 2021?
- What cost changes are expected in 2022?
- How should Medicare payments change in 2022?
- Payment adequacy in context

payment rates. Because updates are cumulative—that is, they compound each year—they are not the preferred policy response to abrupt but temporary changes in demand for health care or resulting health care spending.

The coronavirus pandemic had tragic effects on beneficiaries' health in 2020 and changed the demand for and delivery of health care. In turn, there were material effects on providers' patient volume, revenues, and costs. Moreover, these effects have varied and continue to vary widely across different geographies, across different types of providers, and among individual providers. Although the effects are persisting in 2021, the Commission expects much of the pandemic's impact on health care will be temporary.

Providers' financial status and the pattern of Medicare spending in 2020 have varied substantially from historical patterns. In particular, in the spring of 2020, many sectors of the health care system experienced large reductions in demand for services, resulting in financial distress for some providers. In response, the Congress and CMS extended federal grants to providers and temporarily altered certain Medicare payment policies. At least in part, those actions offset the short-term financial effects of the coronavirus public health emergency (PHE) for many providers. Some providers eventually returned funds to the federal government because their finances recovered faster than expected. Those temporary actions, even if not precisely targeted, were appropriate to a transient problem. Additional temporary relief may be necessary for some providers as the PHE continues.

To fulfill our congressional mandate in regard to payment system updates, we must confine our focus to effects that we expect will impact payment adequacy in the given policy year. As noted above, to the extent the pandemic effects are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies. Nonetheless, if there are changes during the PHE that have effects on providers' cost structures that we expect will persist into 2022 (the policy year for our recommendations), those changes are noted in each sector's payment adequacy discussion and factor into our estimates of payment adequacy. We will monitor the impacts of COVID-19 over time and any lasting effects will be considered as we evaluate the adequacy of Medicare payments in future years.

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professional services, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospices. The

Commission looks at all available indicators of 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 use the best available data and changes in payment policy to project margins for 2021 and make payment recommendations for 2022, accounting for anticipated changes in providers' costs between 2021 and 2022. Because of standard data lags, the most recent complete data we have are generally from 2019. The coronavirus PHE has created additional data lags, most notably for cost reports because the deadlines for their submission were extended. These data lags have affected some health care sectors more than others. Where possible, we have bolstered our data analyses with data from 2020, including interim claims data, information on facility closures, and beneficiary survey data.

In considering updates to payment rates, we may also recommend 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. We may also make recommendations to improve program integrity where we deem it necessary. Our goal is to apply consistent criteria across settings, but because conditions at baseline and anticipated changes between baseline and the policy year may vary, the recommended updates may vary across sectors.

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 in many cases 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.

Our recommendations in this report, if adopted, could significantly change the revenues providers receive from Medicare. Payment rates set to cover the costs of relatively efficient providers help induce all providers to control their costs. Furthermore, Medicare rates also have broader implications for health care spending because they are used in setting payments for other government programs, states, and private health insurance. For example, most Medicare Advantage plans pay hospitals using rates that are comparable with, or based on, Medicare FFS rates (Berenson et al. 2015, Maeda and Nelson 2017); the Department of Veterans Affairs (VA) has been setting payment rates not to exceed FFS rates for most care provided in non-VA settings (Department of Veterans Affairs 2019); the Medicaid program

uses Medicare rates when setting maximum supplemental “upper payment limit” Medicaid FFS payments to hospitals (Medicaid and CHIP Payment and Access Commission 2019, Medicaid and CHIP Payment and Access Commission 2016); and most recently, Montana’s state employee health plan fixed its inpatient and outpatient hospital payment rates to 234 percent of Medicare (Appleby 2018), and Washington limits rates to 160 percent of Medicare for insurers in its new “public option,” which started in January 2021 (Kliff 2019).<sup>1</sup> Thus, while maintaining fiscal pressure on health care providers through payment-rate updates directly benefits the Medicare program, it can also help control health care spending across payers. ■

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## Background

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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 to encourage high-quality care; 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 2022, we first consider whether payments are adequate for relatively efficient providers in 2021. 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 2021. We then consider how providers' costs are likely to change in 2022. Taking these factors into account, we recommend how Medicare payments for the sector in aggregate should change for 2022.

Within any 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 2018b).

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 2016, we recommended the Secretary closely examine the coding practices of certain inpatient rehabilitation facilities that appeared to result in very high Medicare margins (Medicare Payment Advisory Commission 2016b).

We compare our recommendations for updates and other policy changes for 2022 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.

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## Are Medicare payments adequate in 2021?

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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, and Medicare payments and providers' costs for 2021.

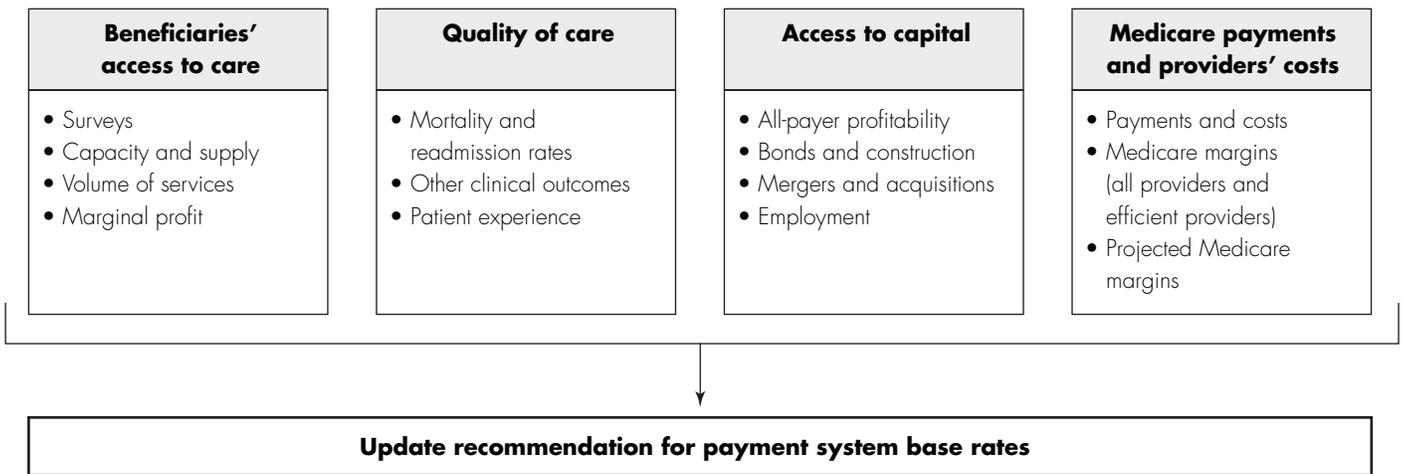
Some measures focus on beneficiaries (e.g., access to care) and some focus on providers (e.g., the relationship between payments and providers' costs). The direct relevance, availability, and quality of each type of information vary among sectors, and no single measure provides all the information needed for the Commission to judge payment adequacy. For example, to inform our assessment of payments for physicians and other health professionals, we conduct a survey of beneficiary access. Ultimately, the Commission makes its recommendations considering as many of these factors as are available. Figure 2-1 (p. 42) shows our payment adequacy framework and an example of the kind of factors used (when they are available) for a sector.

### 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, changes in the delivery of health

**FIGURE  
2-1**

**Payment adequacy framework**



Note:  $\text{Marginal profit} = (\text{Medicare payment} - (\text{total Medicare cost} - \text{fixed building and equipment cost})) / \text{Medicare payment}$   
 $\text{Medicare margin} = (\text{Medicare payments} - \text{Medicare allowable costs}) / \text{Medicare payments}$

Source: MedPAC.

care services, beneficiaries' preferences, local market conditions, supplemental insurance, and other external factors. In March and April of 2020, for example, access was profoundly influenced by the coronavirus pandemic. Many elective procedures were delayed or canceled, and many beneficiaries chose not to visit providers' offices and health care facilities because of the risk of contracting COVID-19 (Czeisler et al. 2020).

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. To the extent that access continues to be affected by the pandemic, we will take that factor into account as well.

**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, as a surgical procedure becomes less invasive, it might be more frequently performed in outpatient settings, freeing up some inpatient hospital capacity. Likewise, as the prices of certain pieces of equipment fall, they can be more easily purchased by providers, increasing the capacity to provide certain services.

Rapid entry of providers into a sector, particularly by for-profit entities, may suggest that Medicare's payments are more than adequate and could raise concerns about the value of the services being furnished. However, 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 the number of providers declines due to closure of facilities, we try to distinguish between closures that have serious implications for access to care 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 since the dual payment-rate system began, 78 LTCHs have closed, representing over 15 percent of facilities and beds. However, the closures occurred primarily in market areas with multiple LTCHs. We note that a temporary reduction in capacity resulting from the pandemic is not an indicator of inadequate Medicare payment rates. However, any permanent changes in capacity may have implications for beneficiary access going forward.

### **Access: Volume of services**

The volume of services furnished by health care providers 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 in aggregate, although it does not necessarily demonstrate that the services are necessary or 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. By contrast, 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, over the last several years, the volume of evaluation and management (E&M) office visits provided in hospital outpatient departments (HOPDs) has increased while the volume of E&M visits in physicians' offices has decreased; this shift in site of service is likely driven by much higher payment rates for E&M visits in HOPDs than in physicians' offices.

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, dissemination of new and improved medical knowledge and technology, deliberate policy interventions, and beneficiaries' preferences. For example, the number of beneficiaries in traditional fee-for-service (FFS) Medicare 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, LTCHs—as expected—changed their admitting practices largely in response to the implementation of the dual payment-rate system, and the number of LTCH admissions decreased markedly.

Changes in the volume of physician services must be interpreted particularly cautiously. Evidence suggests that when payment rates for discretionary services are reduced, providers may attempt to make up for lost revenue by increasing volume—the so-called “volume offset” (Codespote et al. 1998, Congressional Budget Office 2007). Whether a volume offset phenomenon exists within other sectors depends on how discretionary the services are and what the ability of providers is to influence beneficiaries' demand for them.

During the early months of the 2020 coronavirus pandemic, the volume of services provided in many sectors decreased rapidly. In the physician sector, this decline was accompanied by a rapid rise in the volume of telehealth services. By June, the number of office visits and telehealth visits combined was close to the volume experienced for office visits in previous years. (In previous years, the volume of telehealth visits was minimal.) In most other sectors, there was a return in volume to expected levels by late June or July. However, the volume of skilled nursing facility (SNF) services did not fully rebound. Toward the end of 2020, there was an increase in the incidence of COVID-19 and a rise in associated hospitalizations. This trend could affect the volume of services across many sectors that we will monitor throughout the next year.

### **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 in the short term. 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 quality of care and the adequacy of Medicare payment is not direct. Simply increasing payments through an update for all providers in a sector is unlikely to influence the overall quality of care beneficiaries receive because there is no imperative for providers to devote the additional revenue to actions that are known to improve quality. Indeed, historically, Medicare payment systems had created little or no incentive for providers to spend additional resources on improving quality.

The Medicare program has in more recent years implemented 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 relatively low. This issue has been particularly vexing in measuring quality performance for individual clinicians. Second, the Commission has been concerned that Medicare's approach to quality measurement is flawed because it scores too many measures focused on process as opposed to patient outcomes (Medicare Payment Advisory Commission 2018a). 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.

In our June 2018 report to the Congress, we formalized a set of principles for designing Medicare quality incentive programs, which address these issues. In 2019, we applied these principles to recommend a hospital value incentive program that scores a small set of outcome, patient experience, and cost measures, and in 2020, we recommended changing the quality incentive program for Medicare Advantage to better evaluate quality and reward high-quality plans (Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019).

## 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 2021

For most payment sectors, we estimate Medicare payments and providers' costs for 2021 to inform our update recommendations for 2022. 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 is higher if the same inputs are used to produce a higher quality output or if fewer inputs are used to produce the same quality output. 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, 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 2020 and 2021 to our base data (2019 for most sectors). We then model the effects of other policy changes that will affect the level of payments in 2021. Estimated Medicare payments reflect current law and expected volume. To estimate 2021 costs, we consider the rate of input price inflation or historical cost growth, and, as appropriate, we adjust for changes in the unit of service (such as fewer visits per episode of home health care) and trends in key indicators (such as changes in the distribution of cost growth among providers).<sup>2</sup>

### **Use of margins**

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.<sup>3</sup> Margins will always be distributed around the average, and a judgment of 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).

In accordance with our authorizing statute, the Commission also, when feasible, computes a Medicare margin for efficient providers.<sup>4</sup> The Commission follows two principles when identifying 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. For example, in the hospital sector, the variables we use to identify relatively efficient hospitals are risk-adjusted all-condition mortality, risk-adjusted potentially preventable readmissions, and standardized inpatient Medicare costs per case. Our assessment of efficiency is not in absolute terms, but rather, relative to a comparison group—in this example, other inpatient prospective payment system hospitals. (We also make such assessments for the SNF, home health, and IRF sectors.) These assessments of efficient providers in a sector help us identify what may be a reasonable level of costs in a sector and hence the relationship between payments and costs that are needed to support Medicare beneficiaries’ access to relatively high-quality care in that sector.

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. 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 efficient provision of service, we examine recent trends in the average cost per unit, variation in standardized costs and cost growth, and evidence of change in the product. Our goal is to pay enough to provide access to high-quality care for Medicare patients. We do not seek to adjust Medicare payments if other payers under- or overpay. For example, 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 may increase and, all other things being equal, margins on Medicare patients would decrease. Providers that 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. This situation is becoming more common as providers continue to consolidate. We do not lower payments because of generous payments from private

plans or raise them if other payers (for example, Medicaid) pay less. That said, we do recognize that access to care for Medicare beneficiaries will be affected by the payment policies outside of Medicare. Moreover, we recognize that in some sectors, Medicare itself can, 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. For example, in home health care services, one would expect that substantial reductions in the number of visits per 30-day home health care episode would reduce costs per episode. If costs per period 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.

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## **What cost changes are expected in 2022?**

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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.) Forecasts for those price indexes could be uncertain because of the possible volatility of costs in 2020 and 2021. For example, if labor costs for nurses spike in 2021, those costs may then go down in 2022. Estimates of price indexes that include nursing labor costs may be volatile as a result. 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.

This year, to the extent that we anticipate that changes in costs from the pandemic are likely to persist into 2022, those changes are considered in our analyses. For example, we would consider whether facilities are required going forward to make patient rooms single occupancy or negative air pressure.

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## How should Medicare payments change in 2022?

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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 2022 relative to the 2021 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 2021 base payment. For example, if the statutory base payment for a sector were \$100 in 2021, an update recommendation of a 1 percent increase for a sector means that we are recommending that the base payment in 2022 for that sector be 1 percent greater, or \$101. In the event that the Congress or the Secretary does not adopt the Commission’s recommendation for a payment update, current law will continue to apply unless other actions are taken.

When our recommendations differ from current law or regulation, 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 (Medicare Payment Advisory Commission 2016a).

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 that reward one sector over another.

### 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) would 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, recognizing that those services are comparable across the two settings. Specifically, we recommended setting 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, and the Congress enacted a similar reform in the Pathway to SGR Reform Act of 2013 (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 provides their care (Medicare Payment Advisory Commission 2016a). 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 that efficient providers would need to ensure adequate beneficiary access to appropriate care.

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## **Payment adequacy in context**

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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. Therefore, moderating growth trends in Medicare spending per beneficiary is necessary and will require vigilance to be achieved. 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 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. ■

## Endnotes

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- 1 According to the draft affordability standards: “Participating Cascade Care public option carriers are required to cap reimbursement of providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, to one hundred sixty percent (160%) of the total amount Medicare would have reimbursed provider and facilities for the same or similar services” (<http://cascade-care-quality-value-and-affordability-standards.pdf> (wa.gov) (Washington State Health Care Authority 2020)).
- 2 The pandemic had major effects on service use and, in some cases, providers’ costs in 2020. To the extent that those effects continue into 2021, we attempt to factor them into our estimates of 2021 margins.
- 3 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 care 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 about 90 percent of Medicare payments to hospitals), SNF, home health care, 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.
- 4 Section 1805[11] of the Social Security Act [42 U.S.C. 1395b–6]  
  
“Specifically, the Commission shall review payment policies under parts A and B, including—  
  
(i) the factors affecting expenditures for the efficient provision of services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees, (ii) payment methodologies, and (iii) their relationship to access and quality of care for Medicare beneficiaries.”

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