CHAPTER 2

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Chapter summary

The Commission makes payment update recommendations annually for 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 prospective payment system is changed. To determine an update, we first assess the adequacy of Medicare payments for efficient providers in the current year (2010). Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2011). Finally, we make a judgment on what, if any, update is needed. When considering whether payments in the current year are adequate, we account for policy changes (other than the update) that are scheduled to take effect in the policy year under current law. This year, we make update recommendations in 10 FFS sectors: hospital inpatient, hospital outpatient, physician, ambulatory surgical center, outpatient dialysis, hospice, skilled nursing, home health, inpatient rehabilitation, and long-term care hospital. We discuss the analyses of payment adequacy for the first six sectors in this chapter and for the four post-acute care sectors in Chapter 3.

These update recommendations can significantly change the revenues providers receive from Medicare. They also can help create pressure for broader reforms to address the fundamental problem in FFS payment systems—that providers are paid more when they deliver more services

In this chapter

without regard to the quality or value of those additional services. Therefore, each year the Commission looks at all the indicators of payment adequacy and reevaluates any prior year assumptions using the most recent data available to make sure its recommendations accurately reflect current conditions. ■

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

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

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

To help determine the appropriate level of aggregate funding for a given payment system in 2011, we first consider whether payments are adequate for efficient providers in 2010. To inform the Commission's judgment, we examine information on beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs for 2010.

We then consider how efficient providers' costs will change in 2011. Taking these factors into account, we then determine how Medicare payments for the sector in aggregate should change in 2011.

Ideally, we would make our judgments based on the performance of efficient providers in a sector. 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. However, for the most part we are limited by the available data and the analytical state-of-the-art to looking at the aggregate performance in a sector over both efficient and inefficient providers. We have, in some sectors, started to explore ways to approximate the characteristics of efficient providers. For example, last year, we examined the financial performance of hospitals with consistently low risk-adjusted costs per discharge, mortality, and readmissions (Medicare Payment Advisory Commission 2009). This year, we add an analysis of providers' payer mix and the annual level of total fee-for-service (FFS) Medicare service use per capita in the county where the hospital is located.

This year we have also extended our analysis of efficient providers to the skilled nursing facility (SNF) sector. We find that there are some SNFs that have considerably lower costs than other SNFs and substantially better quality results. As our analysis evolves, we plan to continue to refine our identification of efficient providers and extend our efficient provider analysis to other sectors.

Within a given level of funding, we may also consider changes in payment policy that would affect the distribution of payments and improve equity among providers or improve access to care for beneficiaries. We then recommend updates and other policy changes for 2011.

Are Medicare payments adequate in 2010?

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

- beneficiaries' access to care
  - direct measures of access (if available)
  - the capacity and supply of providers
  - the volume of services
- the quality of care
- providers' access to capital
- Medicare payments and providers' costs for 2010

Some measures focus on beneficiaries (e.g., access to care) and some focus on providers (e.g., the relationship between payments and costs in 2010). We consider multiple measures because the direct relevance, availability, and quality of each type of information vary

among sectors, and no single measure provides all the information needed for the Commission to judge payment adequacy.

Beneficiaries' access to care

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

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

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 their costs. Changes in technology and practice patterns may also affect providers' capacity. For example, less invasive procedures or lower priced equipment could increase providers' capacity to provide certain services.

Substantial increases in the number of providers may suggest that payments are more than adequate and could raise concerns about the value of the services being furnished. For instance, rapid growth in the number of home health agencies (HHAs) suggests that Medicare's payment rates are at least adequate and potentially more than adequate and, because the growth has been accompanied by increased cases of fraud, raises concerns over the definition of the benefit. If Medicare is not the dominant payer for a given provider type, changes in the number of providers may be influenced more by other payers and their demand for services and thus may be difficult to relate to Medicare payments. When facilities close, we try to distinguish between closures that have serious implications for access to care in a community and those that may have resulted from excess capacity. Another possible indicator of a sector's capacity and overall financial health is employment, which has been increasing in the health care sector in the past two years even as overall nonfarm employment has decreased. We are exploring the utility of employment as an indicator of capacity and payment adequacy.

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 getting more services and thus must at least be able to access those services—although it does not necessarily demonstrate that the services are convenient or appropriate. Volume is also an indicator of payment adequacy; an increase in volume beyond that expected for 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 benefit is too vague. Reductions in the volume of services, on the other hand, may indicate that revenues are inadequate for providers to continue operating or to provide the same level of services. Finally, rapid changes in volume between services that can be substituted might indicate distortions in payment and raise questions of provider equity.

However, changes in the volume of services are often difficult to interpret because increases and decreases could be explained by other factors, such as population changes, changes in disease prevalence among beneficiaries, technology, practice patterns, and beneficiaries' preferences. For example, the number of Medicare beneficiaries in the traditional FFS program has decreased in some years as more beneficiaries choose plans in the Medicare Advantage program; therefore, we look at the volume of services per FFS beneficiary as well as the total volume of services. Explicit decisions about service coverage can also influence volume. For example, in 2004 CMS redefined conditions it thought appropriate for treatment in inpatient rehabilitation facilities (IRFs) and excluded rehabilitation for most hip and knee replacements, a decision that contributed to a reduction in IRF volume through 2009. However, these cases increased in SNFs and HHAs over the same period, suggesting that beneficiaries' access to care was maintained. Changes in the volume of physician services must be interpreted particularly cautiously, because some evidence suggests that volume may also go up when payment rates go down—the so-called volume offset. Whether this phenomenon exists in any other sector depends on

how discretionary the services are and on the ability of providers to influence beneficiary demand for the services.

Quality of care

The relationship between quality and Medicare payment adequacy is not direct. Some might argue that poor quality is a result of inadequate payments. But increasing payments through an update for all providers in a sector regardless of their individual quality is unlikely to solve quality problems, because there is generally little or no incentive in Medicare payment systems for providers to spend additional resources on improving quality. Medicare's payment systems are not generally based on quality; payment is usually the same regardless of the quality of care. In fact, undesirable outcomes (e.g., unnecessary complications) may result in additional payments, and sectors with more than adequate payments may have little incentive to improve quality.

A fundamental change is needed to change incentives in Medicare FFS payment systems so that better quality is rewarded. The Commission supports linking payment to quality to hold providers accountable for the care they furnish as discussed in our March 2004 and 2005 reports (Medicare Payment Advisory Commission 2004, Medicare Payment Advisory Commission 2005). Specifically, the Commission recommended that pay-for-performance programs be implemented for hospitals, physicians, dialysis facilities and physicians furnishing services to dialysis patients, HHAs, and Medicare Advantage plans (Medicare Payment Advisory Commission 2004, Medicare Payment Advisory Commission 2005). For hospitals and dialysis providers, measures are already available for such a program. For physicians, we described a two-step process that starts with measures of information technology function and moves on to process of care and other measures. In 2008, the Commission recommended that pay for performance be adopted for SNFs (Medicare Payment Advisory Commission 2008). Other sectors may lack quality measures that could be linked to payment and developing such measures should be a priority.

Providers' access to capital

Access to capital is necessary for providers to maintain and modernize their facilities and capabilities for patient care. Widespread inability to access capital throughout a sector might in part reflect on the adequacy of Medicare payments (or, in some cases, even on the expectation of changes in the adequacy of Medicare payments). However, access to capital may not be a useful indicator of the adequacy of Medicare payments when the sector has little need for large capital investments, when providers derive most of their payments from other payers or other lines of business, or when conditions in the credit markets are extreme.

Last year, because of the extraordinary conditions in the credit market, access to capital was being driven almost entirely by factors other than Medicare payment adequacy. For example, health care municipal bond issuances rose to $24.7 billion in the second quarter of 2008 (a level not seen since 1990); the market then essentially froze in late September and virtually no health care entities issued municipal bonds (*Modern Healthcare* 2008). The lack of access to capital in late September 2008 through most of October 2008 was not a result of changes in the adequacy of Medicare payments; it was a result of the conditions in the credit markets. In 2009, liquidity has returned: During 2009, the average rate of bond offerings was $3.4 billion per month, only slightly lower than the record set in early 2008 and on par with 2007 levels. Although markets are returning to a more normal state, any projections about access to capital are still guarded because of the extreme volatility in the credit markets. Conditions will also vary by sector.

A closely allied question is: How will overall economic conditions affect a health care sector's financial performance? For example, the decline in investment portfolios, increasing interest expenses, and possible declines in private payer patient volumes and increases in uninsured patients may lower overall financial performance. But hospitals appear to have controlled their costs in 2009 in reaction to economic conditions. Furthermore, attempting to offset overall economic conditions through increased Medicare payment updates would be a poorly targeted response to economic problems. Base rate increases go to all providers, yet not all providers are equally affected by the economy or equally dependent on Medicare payments. For example, a hospital with few Medicare patients would be hurt more by a decline in employer insurance coverage caused by a declining economy than would a hospital with a high percentage of Medicare patients. Yet an increase in the update would help the second hospital more than the first. Moreover, addressing problems resulting from a poor economy by increasing Medicare payments would either further threaten program sustainability or require increasing taxes.

Medicare payments and providers' costs for 2010

For most payment sectors, we estimate Medicare payments and costs for the year preceding the policy year. In this report, we estimate payments and costs for 2010 to inform our update recommendations for 2011.

For providers that submit cost reports to CMS—acute care hospitals, SNFs, HHAs, outpatient dialysis facilities, IRFs, long-term care hospitals (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 less costs divided by payments. By this measure, if costs increase faster than payments, margins will decrease.

To estimate payments, we first apply the annual payment updates specified in law for 2009 and 2010 to our 2008 base data. In general, we then model the effects of other policy changes that will affect the level of payments, including those—other than payment updates—that are scheduled to go into effect in 2011. This method allows us to consider whether current payments would be adequate under all applicable provisions of current law. The result is an estimate of what payments in 2010 would be if 2011 payment rules were in effect. (Hospitals and dialysis providers are exceptions this year: Hospitals, because of the uncertainty surrounding 2011 policy concerning documentation and coding improvements and information technology subsidies; and dialysis providers, because of uncertainty about the new bundled payment and provider reaction to it. For these two sectors, we model 2010 margins given 2010 policy.)

To estimate 2010 costs, we consider the rate of input price inflation and historical cost growth. As appropriate, we adjust for changes in the product (i.e., changes within the service provided, such as fewer visits in an episode of home health care) and trends in key indicators, such as historical cost growth, and the distribution of cost growth among providers.

Using margins

In most cases, we assess Medicare margins for the services furnished in a single sector and covered by a specific payment system (e.g., SNF or home health services). However, in the case of hospitals, which often provide services that are paid for 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 complementarities of services. (For example, having a hospital-based SNF on average allows a hospital to achieve shorter lengths of stay in its acute care units.) 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 Medicare-allowed costs and payments for all the sectors. The hospital update recommendation in this chapter, however, applies only to hospital inpatient and outpatient payments; the payments for other distinct units of the hospital, such as a SNF, are governed by payment rates for those payment systems.

Total margins—which include payments from all payers as well as revenue from nonpatient sources—do not play a direct role in the Commission's update deliberations. The adequacy of Medicare payments is assessed relative to the costs of treating Medicare beneficiaries, and the Commission's recommendations address a sector's Medicare payments, not total payments.

We calculate a sector's Medicare margin to determine whether total Medicare payments cover average providers' allowable costs and to inform our judgment about payment adequacy. There will always be a distribution of margins about the average and it is not the intent to ensure every provider has a positive 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, unbundling of the services included in the payment unit, and other changes in the product (e.g., reduced lengths of stay at inpatient hospitals). Information about the extent to which these factors have contributed to margin changes may help in deciding how much to change payments.

Finally, the Commission makes a judgment when assessing the adequacy of payments relative to costs. No

single standard governs this relationship for all sectors, and margins are not the only indicator for determining payment adequacy.

Appropriateness of current costs

Our assessment of the relationship between Medicare's payments and providers' costs is complicated by providers' efficiency and response to changes in the payment system, 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 prospective payment system (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 recently introduced a new patient classification system that eventually will result in more accurate payments. However, in the near term, it has resulted in higher payments because provider coding improved, making patient complexity appear higher—although the underlying patient complexity is unchanged. Any kind of rapid change in policy, technology, or product can make it difficult to measure costs per unit of comparable product.

To assess whether reported costs reflect the costs of efficient providers, we examine recent trends in the average cost per unit of output, variation in standardized costs and cost growth, and evidence of change in the product being furnished. One issue Medicare faces is the extent to which private payers are exerting pressure on providers to constrain 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 that are under pressure to constrain costs generally have managed to slow their growth in cost more than those facing less pressure (Gaskin and Hadley 1997, Medicare Payment Advisory Commission 2005). Lack of cost pressure would be more common in markets where a few providers dominate and have negotiating leverage over payers.

In contrast, some have suggested that hospital costs, for example, are largely outside the control of hospitals and hospitals shift costs onto private insurers to offset Medicare losses. This belief argues that costs are immutable and are 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. (See the hospital chapter in our 2009 report for a more complete discussion of the relation between cost pressure and Medicare margins (Medicare Payment Advisory Commission 2009).)

Variation in cost growth among providers in a sector can give us insight into the range of performance that facilities are capable of achieving. For example, if some providers in a given sector have more rapid growth in cost than others, we might question whether those increases are appropriate.

Changes in product can significantly affect unit costs. Returning to the example of home health, substantial reductions in the number of visits in home health episodes would be expected to reduce the growth in costs per episode. If costs per episode instead increased while the number of visits decreased, one would question the appropriateness of the cost growth.

In sum, 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 economic conditions, relative market power, and other factors. Policymakers should accommodate cost growth in payment policy 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 2011?

The second part of the Commission's approach to developing payment update recommendations is to account for anticipated cost changes in the next payment year. For each sector, we review evidence about the factors that are expected to affect providers' costs. A major factor is change in input prices, as measured by the applicable CMS price index. For facility providers, we use the forecasted increase in an industry-specific index of national input prices, called a market basket index. For physician services, we use a CMS-derived weighted average of price changes for inputs used to provide physician services. Forecasts of these indexes approximate

how much providers' costs would rise in the coming year if the quality and mix of inputs they use to furnish care remained constant. Other factors include the trend in actual cost growth, which may be used to inform our estimate if it differs significantly from the market basket.

How should Medicare payments change in 2011?

The Commission's judgments about payment adequacy and expected cost changes result in an update recommendation for each payment system. Each year we look at all the indicators of payment adequacy and reevaluate any prior year assumptions using the most recent data available. In addition, in some cases the update may incorporate an allowance for productivity. Competitive markets demand continual improvements in productivity from workers and firms. These workers and firms pay the taxes used to finance Medicare. Medicare's payment systems should exert the same pressure on providers of health services. Consequently, the Commission may choose to apply an adjustment to the update to encourage providers to produce a unit of service as efficiently as possible while maintaining quality. The Commission begins its deliberations with the expectation that Medicare should benefit from productivity gains in the economy at large (the 10-year average of productivity gains in the general economy, currently 1.3 percent). But the Commission may alter that expectation depending on the circumstances of a given set of providers in a given year. This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay the taxes that fund Medicare.

In conjunction with the update recommendations, we may also make recommendations about the distribution of payments among providers. These distributional changes are sometimes, but not always, budget neutral. Our recommendations for pay for performance are one example of distributional changes that will affect providers differentially based on their performance.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Commission to consider the budget consequences of our recommendations. We document in this report how spending for each recommendation would compare with expected spending under current law. We develop rough estimates of the impact of recommendations relative to the current budget baseline, placing each recommendation into one of several cost-impact categories. In addition, we assess the impacts of our recommendations on beneficiaries and providers.

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 alarmed by the trend in Medicare spending per beneficiary—a growth rate well above that of the economy overall—without a commensurate increase in value to the program, such as higher quality of care or improved health status. If unchecked, the growth in spending, combined with retirement of the baby boomers, will result in the Medicare program absorbing unprecedented shares of the gross domestic product and of federal spending. Slowing the increase in Medicare outlays is important; indeed, it is urgent. Medicare's rising costs, coupled with the projected growth in the number of beneficiaries, will significantly burden taxpayers.

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

In many past reports, the Commission has stated that Medicare should institute policies that improve the value of the program to beneficiaries and taxpayers. These policies should help improve the Medicare payment system. Policies such as pay for performance that link payments to the quality of care providers furnish should be implemented. To reduce unwarranted variation in volume and expenditures, Medicare should collect and distribute information about how providers' practice styles and use of resources compare with those of their peers. Ultimately, this information could be used to adjust payments to providers. Increasing the value of the Medicare program to beneficiaries and taxpayers requires knowledge about the costs and health outcomes of services. Until more information on the comparative effectiveness of new and existing health care treatments and technologies is available, patients, providers, and the program will have difficulty determining what constitutes 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 can create incentives for providing high-quality care efficiently across providers and over time. Some of the current payment systems create strong incentives for increasing volume, and very few of these systems encourage providers to work together toward common goals. Future Commission work will examine innovative policies for the FFS program. Each year, however, the Commission must 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 providers qualify for a payment update each year. ■

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