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REPORT TO THE CONGRESS

Medicare Payment Policy

MEDPAC Medicare
Payment Advisory
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The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission's 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. The Commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. (Meeting transcripts are available at www.medpac.gov.) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlets for Commission recommendations. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

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Glenn M. Hackbarth, J.D., Chairman
Francis J. Crosson, M.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

March 1, 2010

The Honorable Joseph R. Biden
President of the Senate
U.S. Capitol
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
U.S. Capitol
Room H-232
Washington, DC 20515

Dear Mr. Vice President and Madam Speaker:

I am pleased to submit the Medicare Payment Advisory Commission's March 2010 *Report to the Congress: Medicare Payment Policy*. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and to make recommendations to the Congress.

The report contains six chapters:

- a chapter that provides context for those that follow by documenting the rise in Medicare and total health care spending.
- a chapter with five sections that describes the Commission's recommendations on rate updates for six payment systems used by traditional Medicare.
- a chapter with four sections that describes the Commission's recommendations on rate updates for the four post-acute care payment systems used by traditional Medicare.
- a chapter that provides updated statistics on enrollment, plan offerings, and payments in Medicare Advantage plans and repeats our recommendations from previous years.
- a chapter with updated statistics on enrollment and plan offerings for plans that provide prescription drug coverage.
- a chapter responding to a congressional mandate to compare quality among Medicare Advantage plans and between those plans and traditional Medicare, with the Commission's recommendations.

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. Although this report addresses many topics to increase value, its principal focus is the Commission's recommendations for annual rate increases under Medicare's various fee-for-service payment systems. The Commission bases its rate recommendation for each Medicare payment system on an assessment of payment adequacy, including beneficiary access to care, changes in the supply of providers and service volume, quality of care, access to capital, and provider profit margins (where data are available). Annual changes in the rate paid to providers are often referred to as updates.

Updates change the base rate paid by Medicare for each unit of service provided—for example, a hospital admission, a physician visit or procedure, or an episode of home health care. To calculate the ultimate payment for a unit of service, base rates are multiplied by relative values or case weights that reflect the complexity of the services provided as well as by adjustments for geographic variation in input prices.

Managing base rates will not solve the fundamental problem with current Medicare payment systems, discussed in our June 2008 report, that providers are paid more when they deliver more services (fee-for-service), without regard to the quality or value of those additional services. To address that problem directly, the Commission was an early proponent of payment reforms now widely discussed, including “medical homes,” “bundling,” and “accountable care organizations.” Discussion of the details of these proposals is beyond the scope of this letter; suffice to say that each payment reform would attempt to reduce the prevailing incentive to provide more care, especially more complex care. In addition, payment reforms strive to reward better coordination of care, especially for patients with complex conditions.

For two reasons, however, comprehensive reform of Medicare's payment systems is not a ready panacea. First, the new payment models need to be tested and refined; it is one thing to conceptualize a new model but quite another to implement it on a broad scale. Second, reorganization of how care is delivered may be necessary for payment reform to work. For example, “bundling” would pay a lump sum to the hospital, physicians, and post-acute providers caring for a patient during an inpatient admission plus some interval post-discharge (e.g., 30 days). Currently, those providers often act independently of one another and have no formalized means for collaborating, much less for sharing financial risk. Payment reform will often require reorganizing the delivery of care, a complex and time-consuming activity in its own right.

While the Commission maintains that Medicare's payment systems must be reformed, in the interim it is imperative that the current fee-for-service payment systems be managed carefully. As much as reformers—including the Commission—may wish to hasten a sweeping overhaul of Medicare payment systems, Medicare is likely to continue using its current payment systems for some years into the future. This fact alone makes unit prices—both their overall level and the relative prices of different services—an important topic. In addition, unit prices under the current payment systems could affect the prospects for payment reform for the following reasons:

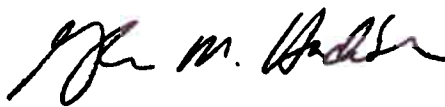
- ***The level of unit prices has an immediate and direct effect on Medicare expenditures.*** By limiting unnecessary updates, the Congress can achieve budget savings and lower beneficiary premiums and cost sharing. Although some critics of Medicare claim that it pays too little for each unit of service, in their 2003 *Health Affairs* article, Uwe Reinhardt, Gerard Anderson, and others found that high unit prices are one of the most important reasons that total U.S. health expenditures per capita are the highest in the world.
- ***By limiting and altering Medicare's unit prices, Medicare provides an impetus for providers to volunteer for experiments with new payment methods.*** Medicare payment reform will often require changes in how providers are organized. Therefore, payment reform will likely need to proceed, at least initially, on a voluntary basis. Voluntary reform poses two challenges: First is the challenge of getting enough volunteers; after all, reorganizing can be difficult work since it may well entail a redistribution of income among

participants. A physician subspecialist, for example, is unlikely to volunteer to participate in an accountable care organization that intends to redistribute income from subspecialists to primary-care providers—unless the subspecialist believes that redistribution is likely to happen under the current payment system. The second challenge is that if there is no financial pressure on providers that choose to stay in the current fee-for-service payment systems, their incentive to take a risk on a new system will be limited—and only providers who expect that they will fare better financially under the new payment method will volunteer. As a result, all other things being equal, voluntary payment reform could increase, not decrease, Medicare expenditures. Steady pressure on unit prices under Medicare’s current payment systems, coupled with appropriate redistribution of payments, will help address both of these challenges.

- ***The relative values used in Medicare’s payment systems signal what the program values and can, by themselves, shape the delivery system.*** On the one hand, inappropriately high unit prices may encourage heavy investment in equipment (e.g., MRI or computed tomography scanners) or programs and facilities (e.g., cardiac specialty hospitals and programs) that institutional providers are then reluctant to abandon. In extreme cases, badly mispriced services may leave the program vulnerable to fraud and abuse. On the other hand, comparatively low unit prices may discourage providers from delivering certain services. Take, for example, the relatively low amount paid for primary care services as opposed to subspecialty services. The comparatively low compensation for primary care has contributed to the dramatic decline in the number of U.S. medical school graduates choosing careers in primary care.

In conclusion, changing Medicare’s payment methods is essential to improving efficiency and value in health-care delivery. But such payment reform is unlikely to happen—or at least will not happen as quickly—without steady pressure on the level of prices paid by Medicare as well as attention to the relative values assigned to different services. We hope this report contributes to that effort.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with a prominent initial "G".

Glenn M. Hackbarth, J.D.
Chairman

Enclosure