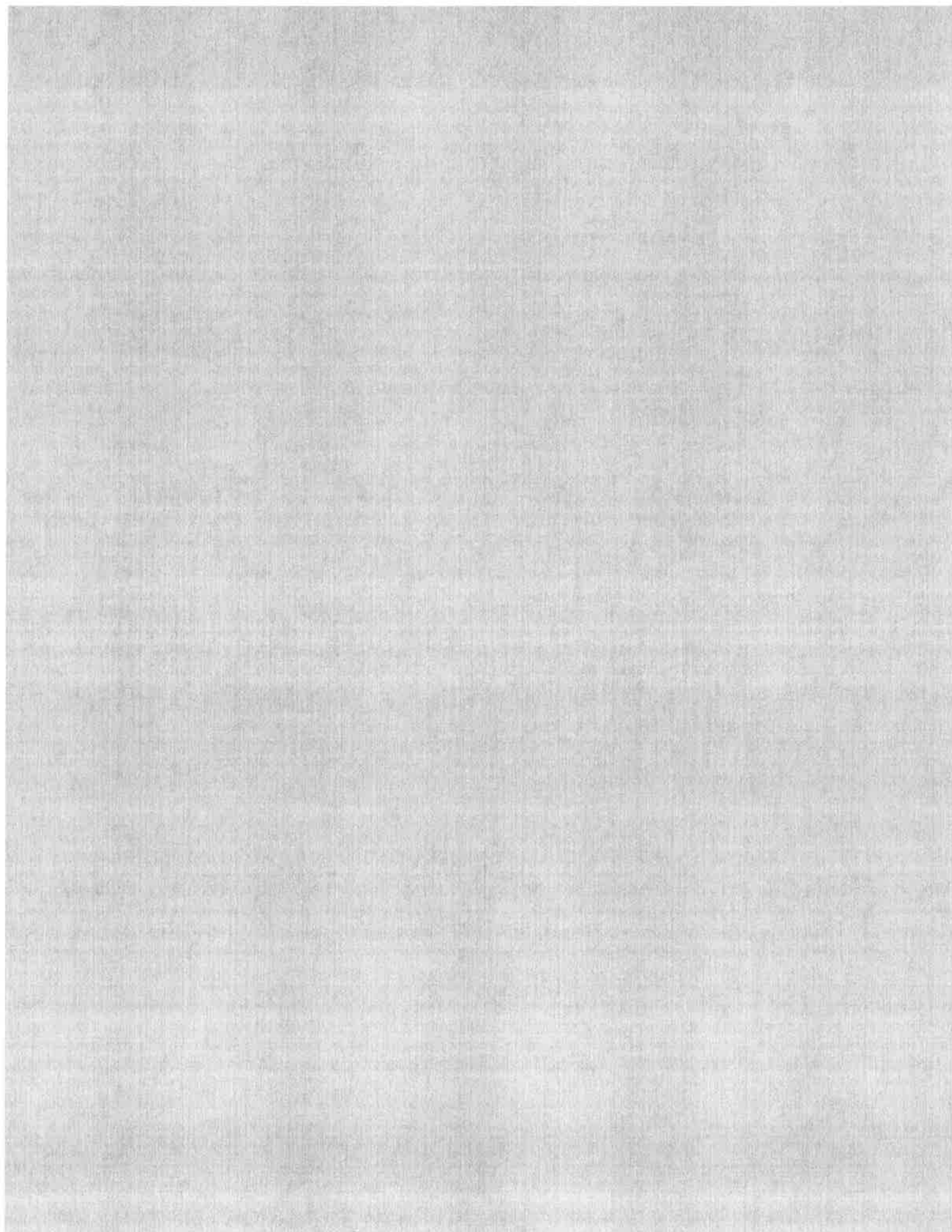
CHAPTER 2

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



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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 providers in the current year (2011) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' cost. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2012). Finally, we make a judgment on what, if any, update is needed.

This year, we make update recommendations in 10 FFS sectors: hospital inpatient, hospital outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation, long-term care hospital, and hospice. These update recommendations can significantly change the revenues providers receive from Medicare and 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 without regard to the quality or value of those additional services.

In this chapter

- Are Medicare payments adequate in 2011?
- What cost changes are expected in 2012?
- How should Medicare payments change in 2012?
- Payment adequacy in context

We also consider other changes that redistribute payments within a payment system to improve equity among providers and to correct any biases that may make patients with certain conditions financially undesirable or particular procedures unusually profitable. 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 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. 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: first, make enough funding available to ensure that payments are adequate to cover the costs of efficient providers, and second, improve payment accuracy among services and providers. Together, these two 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.

In the first step, we endeavor to base our judgment on payment adequacy 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. We have started to explore ways to approximate the characteristics of efficient providers. For example, we continue to examine the financial performance of hospitals with consistently low risk-adjusted costs per discharge, mortality, and readmissions (Medicare Payment Advisory Commission 2009, Medicare Payment Advisory Commission 2010). We also continue our analysis of efficient providers in the skilled nursing facility (SNF) sector. We have found that there are some SNFs that have considerably lower costs than others and substantially better quality (Medicare Payment Advisory Commission 2010). We plan to continue to refine our identification of efficient providers in the SNF and hospital sectors and extend our efficient provider analysis to additional sectors. However, for many sectors we are limited by the available data to assessing the aggregate performance in a sector over both efficient and inefficient providers.

To help determine the appropriate level of aggregate funding for a given payment system in 2012, we first consider whether payments are adequate for providers in 2011. 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 2011. We then consider how providers' costs will change in 2012. Taking these factors into account, we then determine how Medicare payments for the sector in aggregate should change in 2012.

Within a given level of funding, we may also consider changes in payment policy that would affect the distribution of payments among providers within a sector. The intent is to change the incentives and thus improve equity among providers or improve access to care for beneficiaries. For example, we have made recommendations to remove biases in the SNF prospective payment system (PPS) that make treating complex patients less financially desirable than treating patients who need therapy.

We compare our recommendations for updates and other policy changes for 2012 with current law to understand the implications for providers, beneficiaries, 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 do not make multiple-year update recommendations.

Are Medicare payments adequate in 2011?

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
- the quality of care
- providers' access to capital
- Medicare payments and providers' costs for 2011

Some measures focus on beneficiaries (e.g., access to care) and some focus on providers (e.g., the relationship

between payments and costs in 2011). 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. 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 about 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 three years even as overall nonfarm employment has decreased. We continue to explore 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 receiving more services and thus must at least be able to access those services—although it does not necessarily demonstrate that the services are 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 corresponding 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 the volume of services between sectors whose services can be substituted may indicate distortions in payment and raise questions about 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 fee-for-service (FFS) program has decreased in recent 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 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 beneficiaries' 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 historically there has been 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.

The Commission has recommended for the past several years that a fundamental change is needed to create incentives in Medicare FFS payment systems to reward better quality, and the program recently has begun to implement several quality-based payment policies. Specifically, in 2004 and 2005 the Commission recommended that pay-for-performance programs should be implemented for hospitals, physicians, dialysis providers, HHAs, and Medicare Advantage plans (Medicare Payment Advisory Commission 2004, Medicare Payment Advisory Commission 2005). In 2008, the Commission recommended that pay for performance should be adopted for SNFs (Medicare Payment Advisory Commission 2008). CMS is moving ahead with several policies to link provider payments to quality, including an end-stage renal disease (ESRD) quality improvement program for dialysis providers that will apply to ESRD PPS payments starting on January 1, 2012; a Medicare Advantage quality bonus payment program that also will start in 2012; an inpatient hospital value-based purchasing program starting in fiscal year 2013; and a value-based payment modifier, which will combine quality and resource use measurements, for payments to physicians under the physician fee schedule beginning in 2015. The agency is also developing a report to the Congress, due in October 2011, for a plan to implement a value-based purchasing program for SNFs and HHAs. The Commission will continue to encourage CMS to implement these important payment policy reforms and will monitor the agency's progress.

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 may 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). Some sectors, such as hospitals, require large capital investments and access to capital can be a useful indicator. In other sectors, such as home health care, there is little need for large capital investments and access to capital is a more limited indicator. In some cases, a broader measure, such as employment, may be a better indicator of financial health within a sector. Similarly, in sectors where providers derive most of their payments from other payers 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.

The past few years have seen dramatic changes in financial markets. In late 2008, because of the extraordinary conditions in the credit market, access to capital was being driven almost entirely by factors other than Medicare payment adequacy and markets essentially froze. In 2009, liquidity began to return and in 2010 credit markets appear to have returned to more normal conditions under which access to capital depends on borrowers' individual circumstances and credit worthiness.

Medicare payments and providers' costs for 2011

For most payment sectors, we estimate Medicare payments and providers' costs for 2011 to inform our update recommendations for 2012.

For providers that submit cost reports to CMS—acute care hospitals, SNFs, HHAs, outpatient dialysis facilities, IRFs, long-term care hospitals, 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.

In general, to estimate payments, we first apply the annual payment updates specified in law for 2010 and 2011 to our

2009 base data. We then model the effects of other policy changes that will affect the level of payments in 2011. To estimate 2011 costs, we consider the rate of input price inflation and historic cost growth. As appropriate, we adjust for changes in the product, such as fewer visits in an episode of home health care, and trends in key indicators, such as historic 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 may allow 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 Chapter 3, 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 that 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, changes in coding that may change the case-mix adjustment of 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 only one indicator for determining payment adequacy. Moreover, although payments can be known 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 relation of service volume to capacity in any given year.

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 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 was 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 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 that are under pressure to constrain costs generally have managed to slow their growth in cost more than those that face 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 (Berenson et al. 2010).

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 services, 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 2012?

The second part of the Commission's approach to developing payment update recommendations is to consider anticipated cost changes in the next payment year. This step incorporates not only the uncertainties discussed above concerning what cost growth is appropriate but also the uncertainty of any projection into the future. 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 applicable CMS price index. 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 productivity. 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 2012?

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 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.

Choosing the appropriate sector in post-acute care

The recuperation and rehabilitation services that post-acute care (PAC) providers furnish are important to Medicare beneficiaries. Medicare beneficiaries can seek this care in four different PAC settings: skilled nursing facilities, home health agencies, long-term care hospitals, and inpatient rehabilitation facilities. As with any service, Medicare's goal should be to ensure that beneficiaries receive appropriate, high-quality care in the least costly setting appropriate for their clinical condition. However, there are four obstacles to making that determination in the case of PAC:

- Payments are not accurately calibrated to costs in each sector.
- Services overlap among settings.
- The PAC product is not well defined.
- Patient assessment instruments differ among settings.

Refining the prospective payment systems and their case-mix systems will not fully resolve issues of whether patients go to the lowest cost, appropriate post-acute setting or whether they need PAC at all. Some patients may recover and recuperate at home using outpatient services or they may do better by staying a few more days in the acute care hospital. Medicare would also want to make sure that beneficiaries receive the most clinically appropriate and effective care, regardless of the setting. To this end, the Commission is looking beyond payment adequacy to think more broadly about how to match patients who use PAC with the set of services that can provide the best outcomes at the lowest cost. Payments should reflect the characteristics of the patients' care needs, not the setting. ■

The Commission also considers how its update recommendations will affect payment differentials across sectors. A complexity of Medicare is that a beneficiary can sometimes receive a similar service in different sectors. Depending on what sector the beneficiary chooses, Medicare and the beneficiary pay different amounts. For example, patients with joint replacements might go home with home health care or outpatient therapy, to a SNF, or to an IRF upon leaving the hospital, and Medicare payments (and beneficiary cost sharing) can differ widely as a result. Two issues need to be explicated. First, which is the most appropriate setting for the beneficiary to receive the care? Second, do the different payment rates create incentives for providers that might influence the choice of sectors?

Determining the most appropriate setting is not a simple problem. In the text box we discuss the example of choosing the appropriate setting for post-acute care. Paying different amounts for the same service can create problems as well. For example, a beneficiary could receive an identical service in an outpatient clinic or a physician's office. In fact, the same physician could see the same patient and provide the same service, but depending on whether the sign over the door says outpatient clinic or physician office the payment can differ by 50 percent to 60 percent, and the cost to the beneficiary can range from 20 percent of the lower payment to well over 20 percent of the higher payment. In the most extreme case, a beneficiary may have to pay the inpatient deductible for post-acute care in an inpatient post-acute setting rather than nothing in the home health setting.

The Commission, as it makes its update recommendations, may, in some cases, take these payment differentials across sectors into consideration and make sure the relative update recommendations for the sectors do not exacerbate any existing incentives to choose the setting based on payment considerations.

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. For each sector, 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 aging 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. CMS is beginning to take steps on this road such as pay for performance, which links payments to the quality of care providers furnish, and collecting and distributing information about how providers' practice styles and use of resources compare with those of their peers. We discuss these steps in more detail in the sector-specific chapters that follow. Ultimately, 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. New programs such as accountable care organizations may start to address these issues but their impact lies in the future. In the near term, the Commission must 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 providers qualify for a payment update each year. ■

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