
REPORT TO CONGRESS: Medicare Payment Policy EXECUTIVE SUMMARY

The Medicare Payment Advisory Commission's (MedPAC's) March 2006 *Report to the Congress on Medicare Payment Policy* fulfills its legislative mandate to evaluate Medicare payment issues and make specific recommendations to Congress. Much like the health care landscape of the 1990s, the Commission points to the fact that health care spending has been rising much more rapidly than growth in national spending. Also similar to the 1990s, this trend is attributed to the interaction between the broad use of new medical technologies and health insurance coverage, which keeps patients from facing the full costs of health care services. As you read the Commission's recommendations on changing Medicare policy within the broader US health care system, ask yourself, "Has anything really changed?" You may be surprised at your answer.

The Congress charges the Medicare Payment Advisory Commission with reviewing Medicare payment policies and making recommendations concerning them each March. In this report, MedPAC reviews Medicare payment systems for eight sectors: hospital inpatient, hospital outpatient, physician, outpatient dialysis, skilled nursing, home health, long-term care hospitals, and inpatient rehabilitation facilities. The Commission's goal is for Medicare payments to cover the costs efficient providers incur in furnishing care to beneficiaries. MedPAC also recommends changes to payment and other policies that are designed to make payments more accurate and improve the value received by beneficiaries and taxpayers for their expenditures on health care.

This year, for the first time,

MedPAC evaluated payment adequacy for long-term care hospitals and inpatient rehabilitation facilities, two sectors that have been growing rapidly and have seen recent regulatory changes. MedPAC also recommends improvements to the process for determining relative values in the physician payment system and continues to evaluate the relative payments for different services within prospective payment systems (PPSs). Last year, MedPAC made recommendations on improving relative values within the inpatient and skilled nursing facility PPSs.

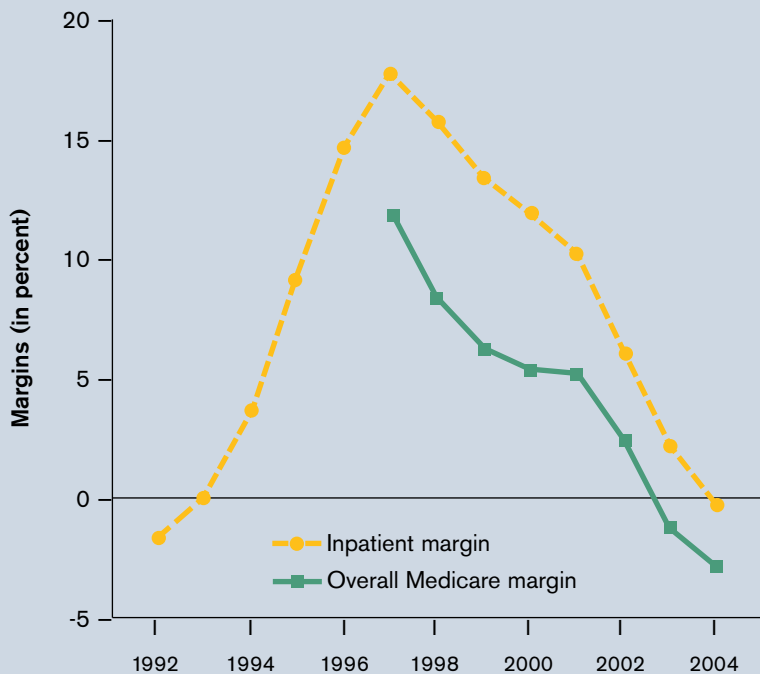
In addition to recommending updates and improvements to the internal relative values that apply uniformly to all providers within a system, the Commission has called for the Medicare program to start differentiating among providers

when making payments. Currently, Medicare pays providers the same regardless of their quality. MedPAC has recommended that Medicare pay more for higher quality performance. Further, the Commission has recommended measuring the resource use of physicians who treat Medicare beneficiaries and providing information about practice patterns confidentially to physicians. These are important steps to improving quality for beneficiaries and laying the groundwork for obtaining better value in the Medicare program.

As the new prescription drug benefit begins, new types of private plans enter the program and new payment systems go into effect, resulting in new patterns of care. In future work, the Commission will analyze these changes and make recommendations to the Congress on how the new programs can be improved to increase their value.

At the beginning of each chapter, MedPAC lists the recommendations contained in it. Within the chapters, each recommendation; its rationale; and its implications for beneficiaries, providers, and program spending are presented. The spending implications are presented as ranges over one- and five-year periods and, unlike official budget estimates, do not take into account the complete package of

Figure 1.
Overall Medicare and Medicare Inpatient Margin



Note: A margin is calculated as payments minus costs, divided by payments; margins are based on Medicare-allowable costs. Analysis excludes critical access hospitals. Medicare inpatient margin includes services covered by the acute inpatient prospective payment system. Overall Medicare margin covers acute inpatient, outpatient, hospital-based skilled nursing facility and home health, and inpatient psychiatric and rehabilitation services, plus graduate medical education.

Source: MedPAC analysis of Medicare Cost Report file from CMS.

policy recommendations, the interactions among them, or assumptions about changes in provider behavior. Appendix A presents a list of all recommendations and the Commissioners' votes.

Context for Medicare Payment Policy

The Medicare program faces powerful upward pressures on health spending that policymakers will find difficult to counter. Chapter 1 describes trends in health care spending and strategies to constrain its growth. Health care spending has been rising more rapidly than growth in national income for many decades, and all indications

suggest that it will continue to do so into the future. The continuation of this trend, combined with the retirement of the baby boomers and Medicare's new prescription drug benefit, will lead the Medicare program to require unprecedented shares of federal spending.

Policymakers need to take steps to slow growth in Medicare spending sooner rather than later because taking measures earlier would permit more gradual changes to the program. Strategies to address Medicare's long-term sustainability include constraining payment rates for health care providers, rationalizing benefits, increasing the program's financ-

ing, and encouraging greater efficiency from health care providers. The last strategy—increasing efficiency—is the most desirable because it would enable the Medicare program to do more with its resources. Even if policymakers succeed at moving providers towards greater efficiency, they may still need to make other policy changes to help ensure that the program's financing is sustainable into the future.

Medicare and its beneficiaries are not alone in facing the challenges of rapid growth in health spending—all stakeholders in the U.S. health care system are confronting similar pressures. Medicare relies on providers and health plans that care for the entire population, not just Medicare beneficiaries, and thus broad trends in the health care system affect the environment in which the program operates. In some areas, Medicare can and should take the lead in initiating changes. But for changes to be lasting, Medicare should work in collaboration with other payers. For example, Medicare could use comparative effectiveness analysis more readily if other payers do so as well, and a common set of measures for quality and resource use across payers would reduce the reporting burden on providers.

Assessing Payment Adequacy and Updating Payments in Fee-for-Service Medicare

Chapter 2 and Chapter 4 recommend payment updates for 2007 and other policy changes for fee-for-service Medicare. To help determine the appropriate level of

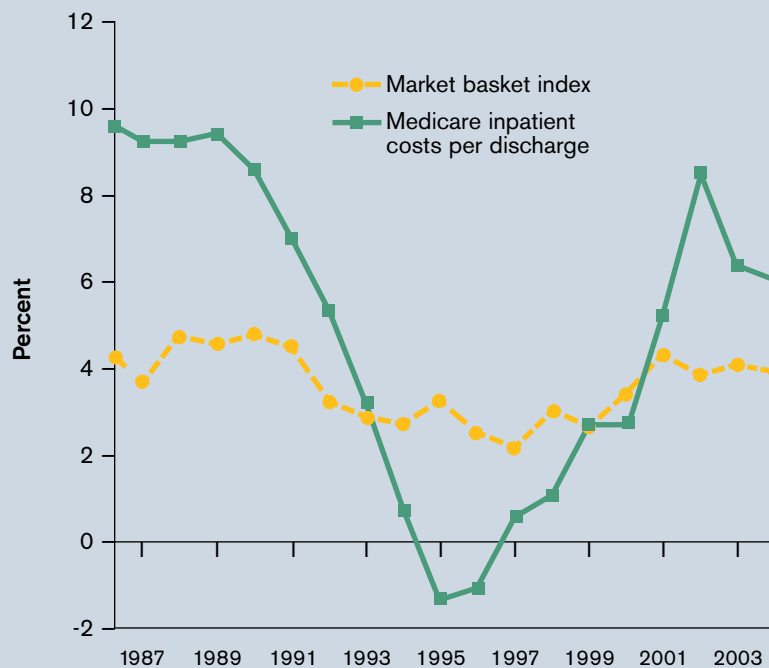
aggregate funding for a given payment system, the Commission considers:

- Are payments adequate for efficient providers in 2006?
- How will efficient providers' costs change in 2007?
- How should Medicare payments change in 2007?

MedPAC answers the question of whether current Medicare payments are adequate by examining information about beneficiaries' access to care; changes in the capacity, volume, and quality of care; providers' access to capital; and, where available, the relationship of Medicare payments to providers' costs. Our assessment of the relationship between Medicare payments and providers' costs is influenced by whether current costs approximate those of efficient providers. Efficient providers use fewer inputs to produce quality outputs. Expected cost changes in the next payment year, such as those resulting from changes in input prices, are then accounted for. As part of this step, a policy expectation for improvement in productivity (0.9 percent for 2007) is applied. This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare. Market competition constantly demands improved productivity and reduced costs; as a prudent purchaser, Medicare should also require some productivity gains each year.

Chapter 2 addresses hospital inpatient and outpatient, physician, and outpatient dialysis services, and Chapter 4 discusses post-acute care services.

Figure 2.
Costs Have Risen Faster than the Market Basket in Recent Years



MedPAC analysis of Medicare Cost Report file from CMS for the acute inpatient prospective payment system.

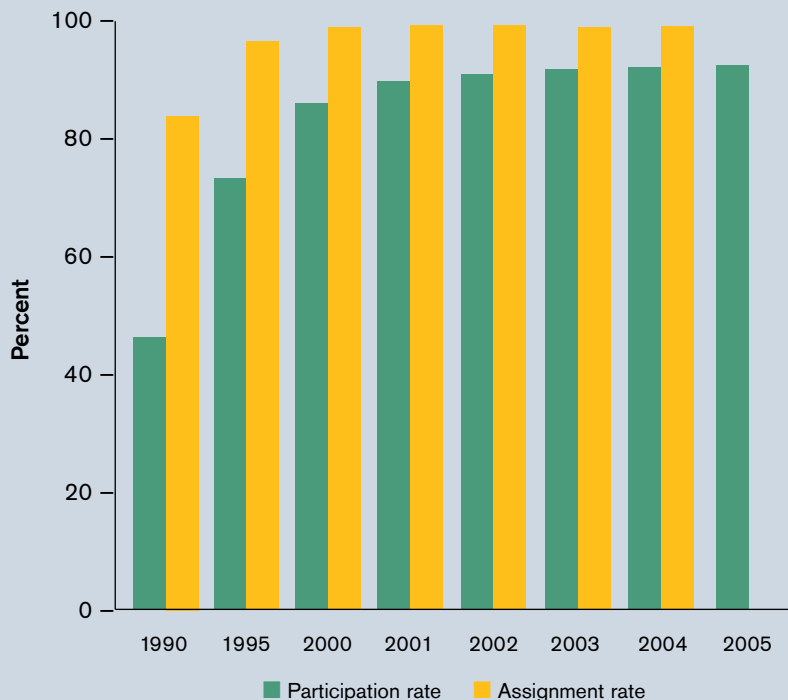
Hospital Inpatient and Outpatient Services

Indicators of payment adequacy for hospitals present a mixed picture. Assessments of beneficiaries' access to care, service volume growth, and access to capital are positive, while the results on quality are mixed. The Commission is concerned about the downward trend in hospitals' overall Medicare margins and the unusually large cost increases in recent years (Figure 1). The rate of cost growth has been affected by unusual cost pressures, but it also has been influenced by the recent lack of financial pressure from private payers as networks broadened and hospitals consolidated. In prior periods when financial pressure from private payers was lacking, hospital costs also grew

rapidly. In addition, this analysis suggests that more efficient hospitals may not be performing as poorly as the industry's aggregate margin would suggest (Figure 2). For example, hospitals with consistently negative Medicare margins have higher costs and lower occupancy than their competitors, and hospitals with high costs substantially reduce the aggregate Medicare margin.

Balancing these considerations, the Commission recommends an update of market basket minus half of MedPAC's expectation for productivity growth for both inpatient and outpatient services. These updates should be combined with a quality incentive payment policy for hospitals and the improvements to the inpatient PPS relative values recommended last year.

Figure 3.
Participation and Assignment Rates Remain at High Levels, 1990–2005



Note: Participation rate is the percentage of physicians and nonphysician providers signing Medicare participation agreements. Assignment rate is the percentage of allowed charges paid on assignment. The assignment rate for 2005 is not shown; it requires calculations from claims not yet available.

Source: Ways and Means Greenbook 2004, unpublished CMS data, and MedPAC analysis of Medicare claims for a 5 percent random sample of Medicare beneficiaries.

Physician Services

The analysis of beneficiary access to physician care, physician supply, Medicare-to-private-fee level comparisons, and the growth in physician service volume finds that many of these indicators are stable and show that the large majority of beneficiaries are able to obtain physician care (Figure 3). Beneficiaries report very high levels of satisfaction with their access to physicians, levels that generally compare favorably to the privately insured. Additionally, the volume of services used per beneficiary continues to grow significantly, which has led to considerable spending increases. In consideration of expected input costs for

physician services and the payment adequacy analysis, the Commission recommends that the Congress update payments for physician services by the projected change in input prices less the expectation for productivity growth for 2007.

In contrast to this recommendation, current law calls for substantial negative updates from 2007 to 2011, under the sustainable growth rate (SGR) formula. The Commission does not support these impending fee cuts because they could threaten beneficiary access to physician services. The Commission is specifically concerned about the effect of rate cuts on access to services provided by

primary care physicians and in the longer term about the attractiveness of primary care to new physicians. Furthermore, the Commission considers the SGR formula a flawed, inequitable mechanism for volume control and plans to examine alternatives to it in the coming year.

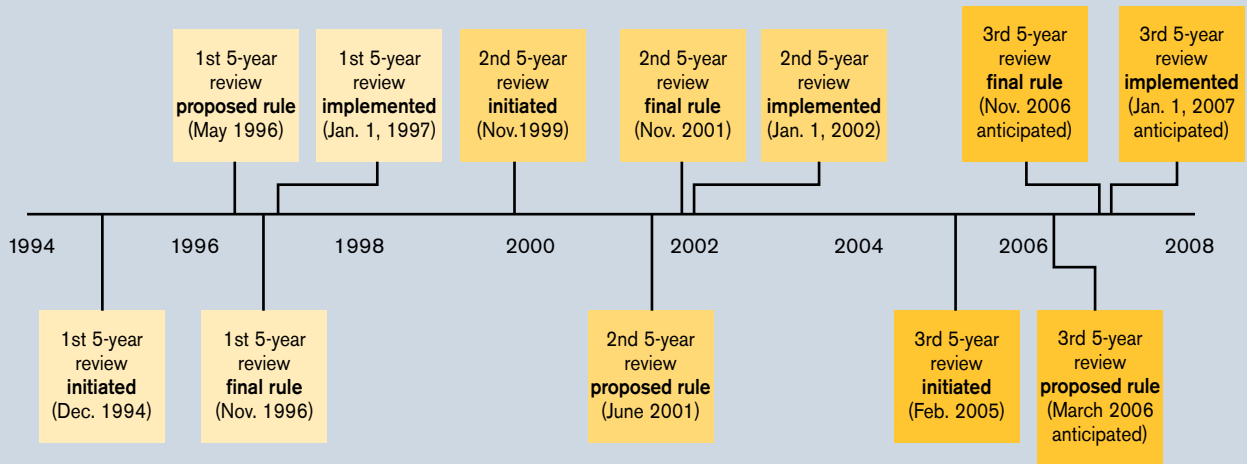
Outpatient Dialysis Services

Most indicators of payment adequacy for outpatient dialysis services are positive. Beneficiaries are not facing systematic problems in accessing care. Providers are increasing capacity to meet patients' demand (as demonstrated by the increasing number of facilities and hemodialysis treatment stations), spending is increasing, and providers have sufficient access to capital. The quality of care is improving for some measures—dialysis adequacy and anemia status—and unchanged for others. Cost per treatment for composite rate services increased at a rate less than CMS's market basket index for dialysis services between 1997 and 2003, but the composite rate was only updated twice in that period.

Although most of the indicators for payment adequacy are positive, the Commission is concerned about the trend and level of Medicare margins for outpatient dialysis services. Balancing these considerations, the Commission recommends updating the composite rate in 2007 by the projected rate of increase in the end-stage renal disease market basket less half of the Commission's expectation for productivity growth.

In addition to updating the

Figure 4.
Five-Year Review Schedule



Note: CMS's proposed changes are published in a proposed rule. The American Medical Association/Specialty Society Relative Value Scale Update Committee's recommendations inform these proposals.

composite rate, the Commission reiterates its recommendation that the Congress eliminate payment differences between free-standing and hospital-based facilities for composite rate services and combine the composite rate and the add-on payment. Doing so is consistent with the principle of paying the costs incurred by efficient providers who furnish appropriate care, regardless of the care setting.

Valuing Services in the Physician Fee Schedule

Relative value units (RVUs) are a key element of Medicare's physician fee schedule. They determine how payment rates vary among all of the more than 7,000 services that physicians furnish to the program's beneficiaries. Periodic review of RVUs is important because the resources needed to perform a service can change over time. When that happens, the value of a service must be changed

accordingly; otherwise, Medicare's payments will be either too high or too low.

Chapter 3 discusses the importance of accurate valuation of physician services and examines CMS's process for reviewing RVUs (Figure 4). Changes to the process are necessary because it does not do a good job of identifying services that may be overvalued. **The Commission recommends improvements to the process that will help reduce the number of physician fee schedule services that are misvalued, thereby making payment more accurate (Figure 4). Inaccurate rates can distort the market for physician services and eventually threaten access to care and affect the supply of physicians—in particular those providing primary care services.**

The Commission recommends that the Secretary establish a standing panel of experts to help CMS identify overvalued services and to review recommendations

from the American Medical Association's Relative Value Scale Update Committee (RUC), and that the Congress and the Secretary ensure that this panel has the resources it needs to collect data and develop evidence. In consultation with this expert panel, the Secretary should initiate reviews for services that have experienced substantial changes in factors that may indicate changes in physician work and identify new services likely to experience reductions in value. Those latter services should be referred to the RUC and reviewed in a time period as specified by the Secretary. Finally, to ensure the validity of the physician fee schedule, the Secretary should review all services periodically.

Post-acute Care Providers

The recuperation and rehabilitation services that postacute care providers furnish are important to Medicare beneficiaries and cost

This year, for the first time, the Commission assesses the adequacy of payment for LTCHs.

the program about \$36 billion in 2004. In Chapter 4, the Commission analyzes payment adequacy for each of the four types of post-acute care providers: skilled nursing facilities (SNFs), home health agencies, long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). The payment systems for all four of these providers face similar issues:

- payments are not well calibrated to costs,
- services overlap among settings,
- the post-acute care product is not well defined, and
- assessment instruments differ among settings.

New prospective payment systems for post-acute care providers have led to changes in the patterns of post-acute care use, and providers' responses to the new incentives of the PPSs may not serve the program or beneficiaries well. **These responses have led to a call for action to slow payments, refine the case-mix systems, and measure quality of care.** However, even refining all of the case-mix systems would still not resolve issues of whether patients go to the right post-acute care setting or whether they need post-acute care at all. There is still no common assessment instrument or front-end assessment tool to sort patients, and no one has an incentive to direct patients to the most cost-effective setting.

Skilled Nursing Facility Services

Most indicators of payment adequacy for SNFs—access to care, supply, payments, quality, access to capital—are stable, and the

volume of services continues to increase. In addition, the Medicare margin for SNFs continues to be high and SNF payments appear more than adequate to accommodate cost growth. Therefore, the Commission recommends that the Congress eliminate the update to payment rates for skilled nursing facility services for fiscal year 2007.

CMS's refinements to the SNF case-mix system in 2006 did not address long-standing problems with the allocation of SNF payments. Therefore, the Commission once again recommends that the Secretary modify the SNF PPS to more accurately capture the cost of providing care to different types of patients. This new system should: reflect clinically relevant categories of patients, more accurately distribute payments for nontherapy ancillary services, improve incentives to provide rehabilitation services based on the need for therapy, and be based on more contemporary data than the current system. Work will continue to further define such a new system.

Currently, CMS has only three quality indicators for SNF patient care, all of which are limited. Medicare urgently needs quality

indicators that allow the program to assess whether patients benefit from SNF care and to distinguish between facilities. The Commission recommends that CMS:

- collect information on activities of daily living at admission and at discharge;
- develop and use more quality indicators, including process measures, specific to short-stay patients in skilled nursing facilities; and
- put a high priority on developing appropriate quality measures for pay for performance.

Home Health Services

Evidence suggests that access to home health services is good. Communities across the country have providers and more providers are entering the program. In addition, the quality of care continues to improve slightly, and the number of users and the amount of service that they use are rising. These factors, along with more than adequate margins, suggest that agencies should be able to accommodate cost increases over the coming year without an increase in base payments. Therefore, the Commission recommends that the Congress eliminate the update to payment rates for home health care services for calendar year 2007.

The Commission continues to be concerned about aspects of this payment system. There is some evidence that payments are not being distributed accurately within the system. The number of visits per episode and the mix of the type of visits (therapy, skilled nursing, and aide) have changed so substantially

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From Profession to Business

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market will dictate and the physician will conform or be forced out by competition.

The third system is the one that will employ the majority of physicians. This system, referred to as "corporate medicine," is now practiced by such corporations as National Medical Enterprise and Hospital Corporation of America. It uses business practices to provide the most efficient health care possible. Corporate HMOs are discussed from three points of view: those of business, the patient, and the physician.

Corporate HMOs work because they remove the market imperfections normally found in medical markets and replace them with incentives for efficiency. From a business point of view, corporate HMOs are efficient by using physician extenders to increase productivity. HMOs are also able to use their size to reduce the costs of the products and services they buy.

The corporate HMOs are able to provide efficient incentives to the patient by offering low deductibles, providing regular office visits and other preventive medical care, and basing the membership fee on the patient's own preventive health care. An example of the latter point is charging a higher fee for smokers than non-smokers, thus providing an incentive to quit smoking.

Incentives for ordering only efficient and necessary procedures are provided to physicians in the form of salaries and profit-sharing. The corporate HMO will also use the concept of DRGs by appointing a primary care physician to be a case

manager. In this role, the primary care physician will receive the DRG allocation to distribute as he deems necessary. So the primary care physician, acting like a governmental HMO, will be responsible for a percentage of the DRG pool of monies. Likewise, he will be responsible for a percentage of the loss, those monies paid out in excess of the DRG pool, as well as receiving a percentage of the profits.

In conclusion, the osteopathic physician has a great opportunity to utilize his or her knowledge of primary care medicine by becoming an efficient case manager. There is little question that the future of medicine will offer room for everyone, but the room at the top will be reserved for those with a workable knowledge of the medical marketplace. MPM

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since the payment system was developed that it is unlikely that the casemix system still accurately predicts the relative costliness of episodes. Ideally, case-mix adjustments should bring payments closer to costs. The Commission will continue to investigate improvements to the payment system.

Long-term Care Hospital Services

This year, for the first time, the Commission assesses the adequacy of payment for long-term care hospitals. LTCHs provide care to patients with clinically complex problems who need hospital-level care for extended periods of time. Medicare is the predominant payer for long-term care hospital services.

Medicare payments for LTCH services are more than adequate. The supply of LTCHs, the volume of services, and the number of beneficiaries admitted to LTCHs have all increased rapidly since 2001. Changes in quality are mixed and access to capital is good. Moreover, Medicare spending for these facilities increased twice as fast as volume, and in 2004 alone, spending increased almost 38 percent. Margins in this sector have been high.

The Commission concludes that long-term care hospitals should be able to accommodate cost changes in 2007 and therefore recommends that the Congress eliminate the update to payment rates for LTCH services for 2007.

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Report to Congress

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Inpatient Rehabilitation Facility Services

This year, also for the first time, the Commission is assessing the adequacy of payment for inpatient rehabilitation facilities. IRFs provide intensive rehabilitation services. **To be eligible for treatment in an IRF, beneficiaries must be able to tolerate and benefit from three hours of therapy per day.**

Indicators of payment adequacy were generally positive through 2004. Supply and volume increased, quality was stable, and access to capital was good. Medicare payments grew rapidly from 2002 to 2004, resulting in high margins for IRFs. A recent regulatory change—CMS's 2004 modification of the 75 percent rule—complicates analysis of this sector. This rule has led to decreased admissions in 2005 and will affect Medicare margins. However, **the Commission estimates margins will still be more than adequate and that IRFs can accommodate price changes without an increase in payments.** Therefore, the Commission recommends that the Congress eliminate the update to payment rates for inpatient rehabilitation facility services for fiscal year 2007. *MPM*

Reprinted from the MedPAC Report to the Congress: Medicare Payment Policy, March 2006.

The highlighted areas are based on those points that the MPM editorial staff feels are most important to our readers.

Opting Out of Medicare

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physician must file an affidavit with their carrier at least 30 days before the first day of the next calendar quarter. Private physicians are not permitted to submit a claim to Medicare for any patient for a period of 2 years. Because this is such a significant option, CMS provides a 90-day grace period after the effective date of the opt-out affidavit during which the physician may revoke their decision, thus returning as a Medicare PAR physician.

Specific information regarding the fee schedule, as well as the Medicare participation physician/supplier agreement is available through local Medicare carriers. In addition, all communications regarding participation need to be provided to local Medicare carriers.

The Decision

The decision to opt out of Medicare and become a private physician is significant. These types of practices are commonly referred to as concert practices. Choosing this option can limit the size of a practice and place a hardship on less affluent patients who are not able to bear physician fees outside of Medicare. Non-PAR status is much less extreme, since Medicare beneficiaries can still receive payment from Medicare. Unlike private physicians who can charge whatever the market can bear, non-PAR physicians are limited to charging just 9.25% above the Medicare-allowable fee, thus limiting the financial benefit of this option.

In conclusion, the level of Medicare participation requires a

Take-Away Message

- PAR—Participating physicians agree to accept what Medicare allows for payment in full for each service for all of their Medicare patients.
- Non-PAR—Non-participating physicians are then allowed to charge their patients above this amount directly, although there are limits on these charges.
- Private—Bill the patient directly, thus having no involvement with Medicare. This is only possible for those who opt completely out of Medicare, becoming private physicians.
- Physicians can only make a change in how they participate with Medicare within defined periods of time.

ROI

- Careful consideration is required based on one's desired practice type and lifestyle, as well as one's market situation before deciding on a change in Medicare participation.
- Clear understanding of the implementation of moving from a PAR Medicare provider to either Non-PAR or private provider is required to achieve the desired outcome.

very careful analysis of one's market potential, desired practice, and lifestyle goals. Clearly, as a new group of seniors is being found with increased wealth that they are willing to spend on their health care at the same time that Medicare is reducing physician reimbursement, many physicians may make this difficult decision and change their level of participation in Medicare. Only time will tell. *MPM*

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