



Research Insights

■ Medicare Payment Innovations in the ACA: Research Insights for Policy

Summary

The Patient Protection and Affordable Care Act (ACA) includes changes in Medicare provider payment rules that were expected to reduce spending by over \$222 billion in the years 2010-2019.¹ Growth in payment rates will continue to be constrained in later years, and the new Independent Payment Advisory Board could recommend further payment cuts if Medicare spending growth exceeds specified targets. The Budget Control Act—the debt ceiling agreement reached in August 2011—includes a trigger mechanism that could lead to automatic Medicare spending reductions of up to 2 percent for each year through 2021. These also would be achieved through cuts in provider payment rates.

While the ACA and the Budget Control Act are designed to steadily squeeze down provider payments, the ACA also offers an alternative route to savings: it provides for widespread experimentation with innovative payment methods—such as bundled payments and pay-for-performance—that are intended to provide incentives for providers to furnish more coordinated and cost-effective care. If these new approaches work, they could offer a more attractive way of controlling costs than arbitrary fee limits.

The ACA payment changes raise urgent questions for policymakers. How far can we squeeze provider payments without jeopardizing access and quality or raising costs for other payers?

Which new payment mechanisms can actually produce savings over the long term? And, more fundamentally, how are we going to collect and assess the data that would let us know on a timely basis whether payment cuts have gone too far, or that one new payment method is better than another?

Introduction

In June 2011, AcademyHealth's Research Insights project convened a meeting that brought leading academic researchers together with policy audiences to review available evidence on these questions and identify areas for further research. Participants engaged in a wide-ranging discussion about provider responses to past payment changes, results of recent experiments with new payment methods, and progress in development of data systems.

Throughout this discussion, one issue emerged repeatedly: the gap between the kinds of information health services researchers are accustomed to producing and the evidence policymakers want to see. Research on new payment approaches has often meant painstaking, carefully controlled evaluation of discrete interventions. But increasingly policy is being made in the context of a legislative and regulatory framework that emphasizes rapid access to concrete information about what's going on in the real world. The demand for hard numbers is likely to be intensified by the current debate over Medicare's role in the nation's long-range fiscal outlook.

Genesis of this Brief

This brief is based on a meeting for federal policymakers in Washington, D.C., on June 2, 2011. AcademyHealth convened the meeting as part of its Research Insights Project with funding from the U.S. Agency for Healthcare Research and Quality (Grant No. 1R13HS018888-01A1). AcademyHealth's Research Insights project provides resources for policy audiences to better understand relevant, rigorous research findings and identifies gaps in the existing research literature. The project convenes policy audiences and researchers in invitational meetings and webinars and commissions literature reviews, background papers, and issue briefs. Additional information and publications may be found on the project's website, <http://www.academyhealth.org/researchinsights>.

Because it is impossible for this brief to adequately cover the full range of topics considered at the June meeting, the focus here is on the portions of the discussion specifically related to evaluation and scorekeeping issues. Even on these issues, the brief is not meant to be comprehensive. It is based on comments by the meeting participants, with some additional information drawn from studies or active research projects referred to in the course of the session. The brief begins with a concise summary of the most important ACA payment provisions. It then examines two of the key topics raised at the meeting: assessment of provider response to payment constraints and the problem of producing timely and credible evaluations of payment innovations.

Key ACA Payment Provisions

Provider payment limits. The ACA limits annual increases in payment rates for most types of providers other than physicians beginning in fiscal year 2012. The update calculation will begin with an estimate of inflation in “input costs”—the costs of wages and other goods and services providers must purchase. This will then be reduced by a productivity adjustment, based on the 10-year average annual increase in economy-wide productivity. (For payments through 2019, the law specifies additional percentage cuts in payment updates. These vary by provider type and year.) Rate increases below the level of inflation will mean that most hospitals and other providers will need to steadily improve their efficiency. (Some classes of providers will instead see payment increases, including hospitals in areas with low Medicare per capita spending and primary care physicians.)²

Independent Payment Advisory Board (IPAB). Beginning in 2014, the IPAB will recommend spending cuts for the following year if projected growth in per capita Medicare spending exceeds specified targets. The recommendations are binding unless Congress adopts other cuts that bring spending within the targets. Targets are initially based on the average of the consumer price index (CPI) for urban residents and the CPI for medical costs; from 2018 on, the target is equal to per capita growth in GDP plus one percentage point.³ Recommended spending cuts may not affect benefits, eligibility, beneficiary premiums, or cost-sharing; until 2020 cuts may not include reductions in payment rates for any of the classes of providers subject to the productivity-related cuts described earlier. While the IPAB has been the subject of much debate, it may actually have little effect in the long run. The CMS Office of the Actuary has projected that the limits on provider payment updates would be sufficient to hold spending growth to the target amounts beginning in 2020; IPAB intervention would be needed only if unexpected utilization growth drove up spending.⁴

Payment innovations. The ACA includes many payment provisions meant to promote delivery system change, improve quality, or meet other objectives. Some of these changes are permanent, such as a program of shared savings with accountable care organizations (ACOs), a pay-for-performance program for hospitals, and payment penalties for hospitals with high levels of preventable admissions or hospital-acquired infections. Other parts of the law provide for pilot programs that may be continued or expanded only if they prove effective; one example is a program of bundled payments, under which an ad hoc organization of relevant providers would be paid for all care surrounding a hospital admission (inpatient, outpatient, physician, and post-acute) for one of a list of specified medical conditions.

In addition to these specific provisions, the ACA creates a new Center for Medicare and Medicaid Innovation (CMMI) to test new payment and delivery methods for Medicare, Medicaid, and CHIP. The law sets out 20 broad models of possible improvements that might be explored by the CMMI, but does not rule out other approaches. The CMMI has so far identified several priorities for its initial efforts: patient-centered medical homes and other primary care initiatives; expansion of ACOs and other coordinated care initiatives; programs to reduce hospital acquired infections and avoidable readmissions; and integration of care for dual Medicare-Medicaid eligibles.⁵

The Centers for Medicare and Medicaid Services (CMS) has always had the authority to conduct demonstration projects to test program innovations—though much of the available funding has often been committed to specific demonstrations mandated by legislation. The CMMI will differ from past research initiatives in two key respects. First, after a model has gone through an initial testing and evaluation period, the Secretary of HHS is given broad authority to continue and expand the use of the model if it is determined to improve quality without raising costs or reduce costs without impairing quality, or to abandon models that are not working. Second, the ACA dramatically expands available funding. It provides \$10 billion for CMMI activities for fiscal years 2011-2019, compared to a total CMS research and demonstration budget of \$39 million in fiscal year 2010. (The ACA-provided funding levels could be reduced somewhat by the Budget Control Act.)

Monitoring The Effects Of Payment Limits

The ACA rules for annual Medicare rate increases are meant to put pressure on hospitals and other providers to hold cost growth below the rate of inflation. As one meeting participant noted, providers may respond in three basic ways: they can improve their efficiency without reducing quality, they can cut costs for their Medicare patients in ways that do potentially threaten quality, or

they can “cost-shift”—make up for Medicare losses by increasing charges to private payers.

Some critics have suggested that health care providers cannot achieve the productivity gains implied by the ACA formulas and that reductions in quality or cost-shifting are inevitable.⁶ As will be seen, there is a vigorous debate about whether cost-shifting is real and about how one might measure it. If it is real, however, cost-shifting could potentially affect the workability of other ACA provisions. Higher charges to private insurers would mean higher private premiums (and higher federal premium subsidy costs), make the individual mandate more onerous, and so on.

Policymakers will certainly want to monitor how providers respond to ACA’s constraints on Medicare payments. But a clear and timely picture of what is going on will require both overcoming data limitations and resolving difficult conceptual questions. The discussion at the meeting focused on research about the effects of Medicare policies on inpatient hospital services, but the issues considered apply to all institutional services.

Conceptualizing cost-shifting. In the aggregate, hospitals’ Medicare margins have been lower than their margins for private patients for many years. The American Hospital Association (AHA) estimates that, in 2009, Medicare paid 90 percent of costs for its beneficiaries, while private payers paid 134 percent of costs. However, there is huge variation among hospitals. One-fourth had Medicare margins of 4.2 percent or higher, while the bottom quartile had margins of minus 17.3 percent or lower.⁷ There are two views about these disparities. One is that some hospitals are better at controlling costs than others and those that are unable to bring their Medicare costs under control must raise private charges to compensate. But studies by MedPAC and others have suggested that the cause and effect could be reversed: hospitals that already have healthy margins from their private patients may face little pressure to improve their efficiency in treating Medicare patients.⁸

Measuring cost. Researchers usually get information on hospital costs from two basic sources: Medicare cost reports submitted to CMS annually and the AHA’s annual hospital survey. Both of these reporting systems allocate costs among payers using highly simplified models.⁹ The resulting data may be more or less reliable in the aggregate—how are all hospitals doing this year?—but may not be meaningful if the aim is to understand trends by payment source at a particular facility or class of facilities. It is likely that many hospitals are collecting more accurate information on payer-specific costs for their own purposes (for example, developing their very complicated charge schemes). Some researchers have had access to a few hospitals’ internal financial data.¹⁰ But even if all hospitals would agree to release this

information, differences in accounting systems are likely to make comparisons difficult.

Time frame. Some studies look at hospitals’ finances in a single year. This approach can give some impression of which hospitals are faring better than others, but may not be much help in understanding the effects of particular Medicare legislation or policies. For this, some form of longitudinal analysis is required. But, it can be difficult to establish whether changes in Medicare costs over time reflect hospitals’ response to payment constraints or other factors such as change in case mix.¹¹ Recent developments suggest another potential hurdle for before/after studies. Medicare spending growth has been slowing down even though the ACA payment constraints have not yet taken effect. Some analysts contend that providers are already cutting costs in anticipation of future losses.¹² If this is so, what should the starting point for any longitudinal study be?

Bargaining power. As noted earlier, some observers contend that hospitals with greater bargaining power in the private market may be more able to cost shift and/or face less pressure to control costs for Medicare patients. However, bargaining power is hard to measure directly, and studies examining this topic have used various proxies, such as a given hospital’s relative share of public versus private patients or the degree of concentration in the hospital industry in the market area in which the hospital operates. None of these measures is entirely satisfactory—in part because they cannot get at the other side of the negotiating table, and in part because of the degree of concentration and bargaining power of insurers in a given market. Participants at the meeting agreed that there was a need for better mapping of delivery patterns and financial incentives at the level of entire geographic market areas.¹³ And again, assessment of market conditions may need to be longitudinal. Participants noted that the effects of Medicare changes enacted in the late 1990s may be hard to disentangle from private market trends, such as the rise and decline of managed care.

Leakage. Research on the effects of payment policy has tended to focus on changes in revenues and costs for hospital inpatient services only. Participants pointed out that one way hospitals can reduce costs for inpatients—rapid discharge—can result in higher costs for post-acute services, such as nursing facility or home health care. This “leakage” can mean that Medicare savings on inpatient care can be offset by higher Medicare spending on other program components. (Or, for beneficiaries with Medicaid or private long-term care insurance, higher spending by these payers.) A further wrinkle is that hospitals, of course, also provide outpatient care and may be part of an organization that provides long-term care and other Medicare services, so that any changes induced by payment constraints may involve realignment of costs and revenues for

a given patient within a single organizational structure. A full understanding of how payment policy affects patient care will require an ability to track patients across settings. This may be particularly important in evaluating the ACA (and possibly the Budget Control Act) rate constraints, because fiscal pressure is being uniformly applied to all types of institutional providers.

Cost-cutting and quality. Hospitals that are less able to cost-shift may face pressure to cut costs, for example by slowing investments in infrastructure or reducing staff. While there is some evidence that this has occurred, it has been difficult to establish whether hospitals are merely cutting fat or whether patient outcomes have been affected. The meeting reviewed one recent study that suggests that quality does deteriorate at hospitals most affected by Medicare payment cuts. However, results on the specific measures used became visible only some years after the cuts took effect.¹⁴ This suggests the importance of developing ongoing tracking that can link specific hospitals' financial performance to trends in outcomes.

One participant at the meeting noted that the possible effects of payment constraints on quality could have troubling implications for some of the payment innovations now under development. For example, current pay-for-performance initiatives that provide bonuses to high-quality hospitals finance those payments by cutting reimbursement to lower-quality hospitals. But the payment cuts could lead to still further deterioration in quality at those hospitals, ultimately creating two tiers of facilities with a steadily widening quality gap.

Measuring The Effects Of Payment Innovations

CMS and its precursor agencies have been testing Medicare payment and delivery innovations for decades. The standard approach has involved a demonstration conducted over multiple years at a limited number of carefully selected sites, with an independent contractor conducting a comprehensive evaluation. One participant cited the Medicare Participating Heart Bypass Center Demonstration as an example of the traditional approach.

In this early experiment with bundled payments, hospitals and their affiliated physicians received a single global payment for all Medicare services associated with a coronary artery bypass graft (CABG). The project began in 1988 with a solicitation to all hospitals that performed CABGs; after a protracted application, review, and negotiation process, the demonstration actually began at four sites in 1991. (Three other sites were added later.) The independent evaluation included both quantitative analysis and qualitative evaluation—such as on-site interviews with participants as the projects took shape. Data collected for analysis

included the usual Medicare claims data, but also medical records (sometimes including actual angiographic films), “microcost” data on spending for patients by individual departments within a hospital, patient and physician surveys, and a set of hospital-reported quality measures. In addition, as a substitute for a true control group, the evaluators collected data and surveyed physicians and patients at competing CABG providers in the same market areas. The final evaluation report was produced in 1998, a full 10 years after the initial solicitation.¹⁵

Meeting participants agreed that this sort of elaborate demonstration and evaluation model would not be workable for the projects to be undertaken by the CMMI. Besides the resources required and the very long time to obtain conclusive results, participants identified a number of other concerns with this way of developing and testing new payment models. Again, the discussion is limited to specific issues raised at the June meeting.¹⁶

Recruiting and selecting the players. The bypass demonstration and many similar projects have been carried out at a few carefully selected sites that may or may not be representative of the broader universe of providers. Sites may tend to be teaching hospitals or institutions like Geisinger Health System or the Mayo Clinic that already have the structures or capacities in place to undertake delivery redesign. And, by definition, providers that volunteer to join a demonstration already have shown that they are interested in innovation. Of the 734 hospitals eligible for the bypass demonstration, 209 expressed preliminary interest and 27 actually submitted a bid to participate. If we don't know what factors—organizational structure, local market, internal politics, and so on—differentiate participants from non-participants, it can be hard to say whether an apparently successful model would work if disseminated more widely.

What would be needed to encourage a broader set of providers to join in payment initiatives? One meeting participant noted that a great many providers were interested in ACOs as long as the concept was defined broadly; once details were established in a proposed rule and people realized they couldn't just do business as usual, interest diminished (more providers may consider participating now that CMS has issued a final rule with less stringent requirements). A possible lesson is that, at least at the outset, new models should be defined fairly loosely, so as to be potentially workable in a variety of delivery systems and organizational cultures. But there are trade-offs. A model can be so vaguely defined that it is unclear just what is being tested. And a model that attracts very wide participation may do so precisely because it creates little pressure for real institutional reform. These issues are considered further below.

Defining the intervention. Meeting participants were of different minds about the right balance between uniformity and flexibility. Some felt that, at this stage, sites participating in pilot projects should be encouraged to explore what works in their circumstances, instead of following a rigid template imposed from above. What might emerge would be a variety of models that apply some broad concept (such as bundled payment or a medical home) in different contexts. One participant cited the Beacon Community Cooperative Agreement Program as a possible model. The 17 communities participating in the program are all using health information technology to improve quality, cost-effectiveness, and population health. But each has set its own goals, based on local priorities and population needs.¹⁷

On the other hand, a proliferation of local variants of a given model might raise the question of whether there is really a single definable intervention being tested across all the sites. Some participants argued that it is essential to declare up front the basic components of the approach that is to be evaluated and not deviate as the project moves forward; otherwise our knowledge of what will and won't work will never advance. Others contended that any new payment model is likely to evolve over time, as barriers are encountered and solutions are developed. In this view, it is desirable to promote a dynamic learning environment, even if this means that clean evaluation design, using predefined performance measures, is difficult.

Context of the intervention. Participants expressed a number of concerns about testing simple interventions in complex systems. First, many of the payment innovations now being evaluated apply to only some subset of providers' populations—people with a specific condition, people identified through an algorithm as “assigned” users of an ACO. While a new payment model may change incentives for treatment of those particular patients, the organization as a whole is still operating under the contrary service-maximizing incentives of traditional fee-for-service. Some participants argued that an evaluation of the success or failure of a particular intervention may not be meaningful if it is adopted in the context of an unreformed system.

On the other hand, outcomes could be obscured because too many interventions are being undertaken simultaneously. For example, a hospital that might be preparing to join in an ACO arrangement is at the same time being subjected to the new inpatient pay-for-performance system and penalties for preventable readmissions, while perhaps also choosing to participate in the bundled payment pilot or other initiatives. If some kind of behavioral change occurs, to which of these interventions would one attribute it? And how would one factor out the broader pressure for greater efficiency that is the point of the general ACA payment constraints?

Still, some participants believed that multiple initiatives occurring at the same time can encourage broader change in an organization's culture. Moreover, it may be that no single payment methodology is going to prove effective for all patients or all conditions. For example, bundling or global payment might work for some types of cases and not others. In this case, providers and purchasers—as well as scorekeepers—are going to have to learn to cope with an environment where multiple payment approaches and incentive structures are in place at the same time.

Measuring success. An elaborate evaluation, like that of the bypass demonstration, can use multiple data sources and approaches to try to isolate the effects of a specific initiative. The evaluation was designed not just to measure results on a set of specified outcome measures, but to determine *how* the results were achieved—what specific changes in physician behavior or hospital management brought savings or improved appropriateness of care? If time or funding limitations preclude this sort of multifaceted evaluation, the alternative is to specify a more limited set of measures and assume that improvement on those measures must be attributable to some kind of system change. Participants noted that the reliability of this kind of evaluation—using “proxy” measures—depends on whether it is possible for a provider to improve its score on the specific measure *without* general system reform. This has been a frequent issue with pay-for-performance programs. A response offered by one participant was that paying even for very narrow and targeted improvements would at least signal an emphasis on quality rather than volume. Others argued that use of a limited set of specific measures poses some risk of gaming—for example, diverting or dumping patients likely to have adverse outcomes. Correcting for this through risk adjustment requires more extensive upfront data collection (for example, better information on conditions present at an initial inpatient admission or outpatient encounter).

Limits of available data. Evaluations, of course, depend on data, and much of the discussion at the June meeting centered on issues of data collection. As participants noted, Medicare claims data, while they are the one uniform and readily available source of information on every fee-for-service beneficiary, are of limited use to evaluators. They can be used for utilization and cost estimates, but not for quality measurement—except to the extent that quality can be imputed through indirect measures or intermediate outcomes such as incidence of avoidable ambulatory-care sensitive admissions.¹⁸ In addition, while claims data can be used to profile beneficiaries—individually or as population groups—it is hard to assemble profiles at the level of practitioners, organizations, or health systems. There are also issues of timeliness: delays in submission, processing, and compilation of data from claims can mean that both participants in an initiative and evaluators can be left without meaningful information for months or years.

While the government and providers at all levels are now investing heavily in health information technology, it may be some time before these efforts yield the kinds of data needed for evaluation of payment initiatives. Understandably, the immediate focus has been on systems that can produce direct improvements in patient care—for example, ensuring appropriate referrals or improving communication between providers when patients are handed off. The “meaningful use” requirements for the Medicare and Medicaid electronic health record (EHR) incentive program include some capacity to exchange information among providers using different systems, along with collection of data on a limited set of clinical outcome indicators. Still, as one participant noted, there remain major barriers to the cross-provider aggregation that will be needed to obtain a comprehensive view of a patient’s care. And the clinical measures being collected by different providers may or may not be relevant for the assessment of any particular payment initiative.

The usual solution in the past has been to require providers participating in a given initiative to collect and report a set of measures developed specifically for evaluation of that initiative—whether or not the providers would be collecting these measures for any other purpose. For example, the proposed rule for the ACO shared savings program specifies 65 measures to be reported by organizations, some to be collected through patient surveys or claims data, but most to be extracted from provider records, electronically if possible but otherwise manually. The final rule reduces the number of measures to 33, but data collection may still be burdensome for some provider groups. The rule also indicates that CMS may “refine and expand” the list of measures in the future.¹⁹ As one observer has noted, organizations may be discouraged from participating if they not only have to make an immediate investment to collect the needed data, but face the possibility of unpredictable future revisions.²⁰

This problem is likely to be compounded if, as suggested earlier, providers are going to be expected to participate in multiple Medicare payment initiatives at the same time, or if other payers are also pressing for their own defined data sets. One participant suggested that it would be preferable to settle on a limited set of data elements that would be collected during testing of a variety of models. Minnesota’s current health reform initiatives were cited as an example; providers were encouraged to participate by being assured that a common set of measures would be collected for divergent needs. But another participant expressed concern that the result would be a lowest-common-denominator data set that might not be adequate for evaluations.

Sustaining Innovation In An Era Of Austerity

In effect, the ACA has set up a sort of race: can payment and delivery reforms be implemented rapidly enough to obviate the need for ever more stringent across-the-board payment limits? As noted earlier, many people argue that the ACA limits are unsustainable over the long run. Some meeting participants responded that “sustainable,” for providers, means maintaining payment levels that will allow them to continue doing business the way they do today. In this view, one virtue of looming, unsustainable cuts is that they put pressure on providers to participate in new models and make them work. A contrary view is that providers may resist payment reforms if they believe that Congress will eventually blink, overriding what are supposed to be automatic payment limits if access and quality appear to be threatened. This has been the experience so far with the physician payment limits established under the “sustainable growth rate” system enacted in 1997; Congress has passed temporary reprieves 11 times in the last eight years.²¹

Supposing that continued pressure on payment levels will induce providers to embrace real systemic reform, there will still be at least two hurdles to cross before innovative payment models can become a permanent part of the system. First, before expanding use of a given model, the CMMI must compile enough evidence to persuade the CMS Office of the Actuary that the model saves money, or at least doesn’t increase costs. This is a pass/fail test: a model that saves \$1 passes. However, the Actuary has in the past been very conservative in assessing the effects of innovations. For example, when the ACA was enacted, the Congressional Budget Office (CBO) estimated that the CMMI and the ACO shared savings provisions would save a combined \$6.2 billion in 2011-2019. The CMS Actuary predicted zero savings from these provisions.²² Meeting participants agreed that it would be very important for the CMMI and the Actuary to establish, early in the development and testing process, what standards of proof are going to be applicable and what kinds of evidence will be acceptable.

Even if new payment models become operable and are saving lots of money, providers will still face sharp rate constraints unless Congress acts to modify the ACA rules. If the current focus on budgetary restraint continues, Congress might have to be persuaded—and the CBO would need to certify—that adoption of a new payment model will fully offset the cost of any relief from the rate-setting rules. This is not a pass/fail test, like the CMMI standard, but requires numbers. And these numbers may need to be generated quickly. As meeting participants pointed out, the ACA rules will be steadily squeezing down the current law baseline against which payment innovations will be measured, so the test will get tougher every year.

As some other observers have pointed out, major past changes in Medicare payment methodologies were not necessarily the result of systematic experimentation and evaluation.²³ Prospective payment for inpatient hospital services, based on assignment of cases to diagnostic related groups (DRGs), was tested very briefly in New Jersey beginning in 1980. But the New Jersey system had not even been fully phased in, much less formally evaluated, when Congress adopted it as the national Medicare model in 1983.²⁴ The physician fee schedule, which bases payments for physician services on the relative value of the resources required to produce them, was mandated in 1989 and took effect in 1992. It had never been tested at all. In both these cases, Congress enacted a sweeping reform and only later found out how it worked—who was winning and losing, what changes were needed to make the reform work, and so on.

This approach may have been possible, in part, because neither of the new systems was initially expected to save any money. The DRG system was adopted just a year after the 1982 Tax Equity and Fiscal Responsibility Act, which imposed what were perceived as draconian limits on the growth in hospital payments. The new system was designed to be budget-neutral, giving hospitals incentives for improved efficiency without imposing additional system-wide cuts. The physician fee schedule was also meant to be budget-neutral at the outset: it redistributed funds from surgical and diagnostic procedures to cognitive services without providing immediate savings. The lack of budgetary pressure meant that these sweeping changes could be adopted without strong evidence that they would work. Perhaps another factor that made these large-scale reforms possible was that Congress could tinker with them after they were enacted. Technical problems were addressed as they became apparent, on a bipartisan basis.

Of course, bipartisanship was reinforced by strong pressure from providers and other stakeholders to correct distortions and inequities in the payment systems. Because health care providers are vital to the economy of every district and Medicare beneficiaries can decide elections, pressures to maintain access to care are still likely to trump ideology, even in the current, less amicable environment. So there is some reason for optimism that Congress will embrace more flexible approaches before rigid payment limits begin to compromise quality. Health services researchers can play an important role in this process, by documenting the effects of the ACA's payment changes and by developing faster but credible ways of evaluating the success of new payment approaches.

About the Author

Mark Merlis is an independent health policy consultant.

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Endnotes

- 1 The figure excludes cuts in Medicare Advantage payments and new revenues. Mark Merlis, *Adding Up the Numbers: Understanding Medicare Savings in the Affordable Care Act*, Washington: Center for American Progress, Oct. 2010.
- 2 As noted earlier, the Budget Control Act could mean payment reductions of two percent in each year through 2021. However, these reductions would not affect cumulative rate updates; 2022 rates would be calculated as if the sequestrations had never occurred.
- 3 Regardless of the targets, the total amount that can be cut in any given year is limited; the annual limit starts at 0.5 percent of program spending for 2015 and rises to 1.5 percent for 2018 and later years.
- 4 Office of the Actuary, CMS, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," memorandum, April 22, 2010.
- 5 Rachel Nuzum and Stuart Guterman, "The Sweet Spot Between 'Rigor' and 'Rigor Mortis': Balancing the Need for Evidence-Based Innovations and Rapid-Cycle Change," The Commonwealth Fund Blog, July 19, 2011, <http://www.commonwealthfund.org/Blog/2011/Jul/Evidence-Based-Innovations-and-Rapid-Cycle-Change.aspx>.
- 6 Office of the Actuary, "Estimated Financial Effects."
- 7 Medical Payment Advisory Commission (MedPAC), *Data Book: Health Care Spending and the Medicare Program*, Washington, June 2011.
- 8 Jeffrey Stensland, Zachary R. Gaumer and Mark E. Miller, "Private-Payer Profits Can Induce Negative Medicare Margins," *Health Affairs*, v. 29, no.5 (2010):1045-1051.
- 9 For example, both Medicare and AHA estimate costs for Medicare patients at each hospital by using that hospital's overall cost-to-charge ratio; the estimate may be inaccurate if the ratio is actually different for Medicare and other patients.
- 10 James Robinson, "Hospitals Respond To Medicare Payment Shortfalls By Both Shifting Costs And Cutting Them, Based On Market Concentration," *Health Affairs*, v. 30, no.7 (2011):1265-1271.

- 11 The meeting looked closely at one study that seeks to isolate the effects of the payment policy changes in the 1997 Balanced Budget Act by holding case mix and other factors constant and estimating a “BBA bite”—how each hospital would have been affected by new payment rules with no behavioral change. Vivian Y. Wu, “Hospital Cost Shifting Revisited: New Evidence from the Balanced Budget Act of 1997,” *Int J Health Care Finance Econ* (2010) 10:61–83.
- 12 Maggie Mehar, “Medicare Spending Slows Sharply; Zeke Emanuel Is Not Surprised,” *HealthBeat*, Aug. 12, 2011, <http://www.healthbeatblog.com/2011/08/medicare-spending-slows-sharply-few-seem-to-notice-part-1.html>.
- 13 For a discussion of how this mapping might work, see Laura Tollen et al., *Delivery System Reform Tracking: A Framework for Understanding Change*, New York, The Commonwealth Fund, June 2010.
- 14 Vivian Y. Wu and Yu-Chu Shen, *The Long-Term Impact of Medicare Payment Reductions on Patient Outcomes*, Cambridge, MA, National Bureau of Economic Research, NBER working paper 16859.
- 15 Health Economics Research, *Medicare Participating Heart Bypass Center Demonstration: Final Report, 1998*, http://www.cms.gov/DemoProjectsEvalRpts/downloads/Medicare_Heart_Bypass_Executive_Summary.pdf.
- 16 Readers interested in an additional perspective on evaluations might wish to read a recent Commonwealth Fund brief: Marsha Gold, David Helms, and Stuart Guterman, *Identifying, Monitoring, and Assessing Promising Innovations: Using Evaluation to Support Rapid Cycle Change*, New York, The Commonwealth Fund, June 2011.
- 17 Information on the Beacon program is available at the website of the National Coordinator of Health Information Technology, <http://healthit.hhs.gov/portal/server.pt?open=512&objID=1805&parentname=CommunityPage&parentid=2&mode=2&cached=true>
- 18 Some physicians are reporting quality measures on claims as part of the CMS Physician Quality Reporting System, but this is not required.
- 19 Centers for Medicare and Medicaid Services, “Medicare Shared Savings Program: Accountable Care Organizations,” final rule, scheduled for publication November 2, 2011, preprint available at: http://www.ofr.gov/OFRUpload/OFRData/2011-27460_pl.pdf.
- 20 Paul Ginsburg, “Spending to Save — ACOs and the Medicare Shared Savings Program,” *N Engl J Med*, 364:22 (June 2, 2011).
- 21 Mark Merlis, “Health Policy Brief: Paying Physicians for Medicare Services,” *Health Affairs*, Updated December 16, 2010, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=36.
- 22 Congressional Budget Office estimates provided in March 20, 2010, letter from Douglas Elmendorf, Director, CBO, to Speaker Pelosi; Office of the Actuary, “Estimated Financial Effects.”
- 23 Marsha Gold, David Helms, and Stuart Guterman, *Identifying, Monitoring, and Assessing Promising Innovations: Using Evaluation to Support Rapid Cycle Change*.
- 24 W. C. Hsiao, H. M. Sapolsky, D. L. Dunn, and S. L. Weiner, “Lessons of the New Jersey DRG Payment System,” *Health Affairs*, v. 5, no.2 (1986):32-45.