Care CEU's
Continuing Education for Nursing Home Administrators

Medicare Payment Basics

AMBULANCE SERVICES PAYMENT SYSTEM

Ambulance services include both emergency and nonemergency transport from the point of patient pick-up to an appropriate medical facility. Medicare beneficiaries use ambulance services for a variety of reasons, such as unscheduled emergency transports to a hospital emergency department; scheduled nonemergency transport from inpatient care to a skilled nursing facility (SNF); and scheduled repetitive nonemergency transports to and from dialysis facilities. In 2011, 5.2 million Medicare beneficiaries (15 percent of fee-for-service (FFS) beneficiaries) enrolled in traditional FFS Medicare used an ambulance service. These ambulance services were provided by over 11,000 individual entities that billed Medicare for ambulance services in 2011. These entities are defined as either suppliers (non-institutionally based, e.g., the local fire department or private for-profit entities) or providers (institution based, e.g., affiliated with the local hospital). Medicare program spending for ambulance services in 2011 was $5.3 billion, or about 1 percent of total Medicare spending.

Ambulance services are largely a Medicare Part B service, and Medicare pays for Part B ambulance services using a dedicated fee schedule, which has payment rates for nine separate payment categories covering ground and air ambulance transports. In determining payment rates for each category of services, the Centers for Medicare & Medicaid Services (CMS) considered the historical costs associated with each payment category to establish relative values for each. These relative values are multiplied by a dollar amount that is standard across all of the nine categories, adjusted for geographic differences, and added to the mileage component of the payment to arrive at a payment amount. Medicare payments for ambulance services may also be adjusted through one of several add-on payments based on additional geographic characteristics of the transport.

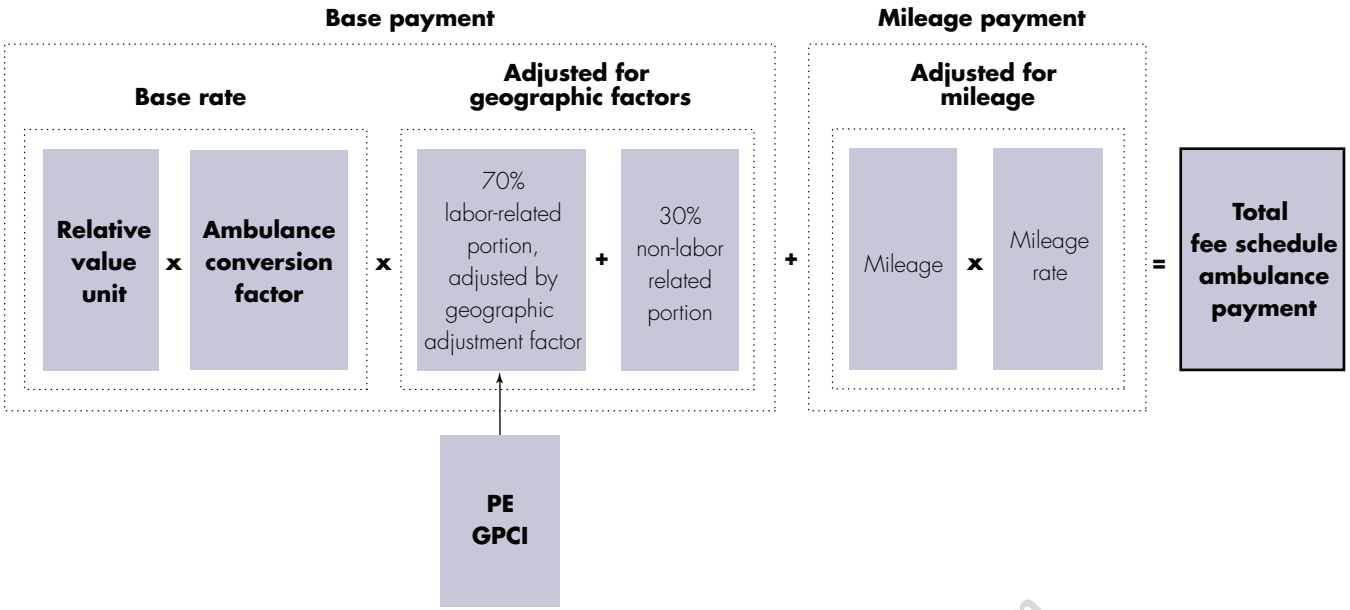
Coverage

Medicare Part B covers ambulance services in cases where other transportation could endanger the life of the beneficiary. Specifically, Medicare pays for ambulance services furnished to a beneficiary only if: actual transportation of the beneficiary occurs, the beneficiary is transported to an appropriate destination, the transportation by ambulance is medically necessary (i.e., the beneficiary's medical condition is such that other forms of transportation are medically contraindicated), the ambulance supplier/provider meets all applicable state requirements, and the transportation is not part of a Part A service.[1] In addition, Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare for ambulance transports.

Medicare Part B covers 80 percent of the Medicare-approved amount of the ambulance trip. Therefore, the beneficiary pays approximately 20 percent of the Medicare approved amount, after the beneficiary has paid the yearly Part B deductible ($147 in 2013).[2]

Ambulance transports occurring during a Medicare Part A stay in an inpatient hospital or skilled nursing facility (SNF) are generally included within the Part A payment and do not result in a separate Part B payment. Once the beneficiary has been admitted into a Medicare Part A stay, a separate Part B payment is allowed for an ambulance transport when a beneficiary is transported: from the SNF to a hospital for the specific purpose of receiving emergency services or intensive

Figure 1 Ambulance fee schedule equation



Note: PE (practice expense), GPCI (geographic practice cost index).

outpatient services not available at the SNF, from the SNF to a dialysis facility, or between two separate Part A stays. In addition, ambulance transports that precede a Medicare Part A stay are reimbursed under Part B and are not bundled into the Part A stay as a part of Medicare's 72-hour rule.

Setting the payment rates

Medicare's ambulance fee schedule pays suppliers and providers a single payment to cover both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with the transport. Therefore, the single payment is inclusive of items and services such as oxygen, drugs, extra attendants, and EKG testing when such services are medically necessary.

Standard fee schedule formula The ambulance fee schedule has two components: a base payment and a mileage payment, which are summed to arrive at the total Medicare payment for each ambulance transport. The base payment consists of the product of three distinct pieces: the relative value unit (RVU), which determines the relative intensity or service level of the ambulance transport; a conversion factor (CF), which is used to convert the RVU into a payment expressed in monetary terms; and a geographic adjustment factor (GAF) to account for the geographic differences in the cost of providing ambulance services. The payment for the mileage component of the ambulance fee schedule reflects the costs attributable to the use of the ambulance vehicle (for example, maintenance, fuel, and depreciation), and is the product of miles traveled with the patient and a mileage rate determined by CMS (Figure 1).

Base payment The ambulance fee schedule contains nine distinct levels of ambulance service, and each of these is assigned a different RVU representing the varying levels of service intensity required to serve the patient (Table 1). Service intensity varies based on whether the transport is emergency or nonemergency and the level of clinical staff required (basic life support

staff (BLS) or advanced life support (ALS) staff). RVUs for eight categories of ambulance transports are set relative to the value of the lowest intensity service, BLS nonemergency ambulance transport, which is assigned an RVU of 1.00. Seven of the service levels are specific to ground ambulance transports, and two are specific to air ambulance transports. Despite a generally higher level of service intensity, the RVU for both of the air ambulance transport levels is set at 1.00, and the fee schedule accounts for higher costs associated with air transports through the conversion factor.

The conversion factor used for the ambulance fee schedule is a dollar amount used to convert the RVU of a given ambulance case into a payment. For 2013, the CF for all ground ambulance transports was $216.19. The two types of air ambulance transports each have their own CF to account for the higher costs and service intensity associated which each type of service. For 2013, the fixed-wing (FW) CF is $2,953.78 and the rotary-wing (RW) CF is $3,410.96.

The non-facility practice expense component of the geographic practice cost index (GPCI) is the GAF that is used to address regional differences in the cost of furnishing ambulance services within the national ambulance fee schedule. The ZIP code in which the Medicare beneficiary was picked up by the ambulance, referred to as the point-of-pickup ZIP code, establishes which GPCI is applied to generate the base payment. The GPCI applies to 70 percent of the base payment for ground ambulance transports and to 50 percent of the base payment for air ambulance transports.

Mileage payment The payment for the mileage component of the ambulance fee schedule reflects the costs attributable to the use of the ambulance vehicle (e.g., fuel, maintenance, and depreciation) and is the product of two parts: raw mileage multiplied by a mileage rate determined by CMS. The term 'mileage' is referred to by CMS as 'loaded miles,' or the miles an ambulance travels with the beneficiary from the point-of-pickup to the location of the nearest appropriate facility. This amount is reported by the provider or supplier of the ambulance, reported on the claim submitted to Medicare, and used to calculate the payment amount for the claim. The mileage rate is a standardized amount established by CMS and differs for ground and for the two modes of air ambulance transport. In calendar year 2013 the ground ambulance mileage rate was $6.95 per statute mile, the FW mileage rate was $8.32, and the RW mileage rate was $22.21.

Table 1 Medicare ambulance service levels and conversion factors, 2013

Ambulance service level	RVU	CF
Ground transports		
BLS nonemergency	1.00	$216.19
BLS emergency	1.60	$216.19
ALS nonemergency	1.20	$216.19
ALS emergency (level 1)	1.90	$216.19
ALS emergency (level 2)	2.75	$216.19
Specialty care transport	3.25	$216.19
Paramedic ALS intercept	1.75	$216.19
Air transports		
Fixed wing	1.00	$2,953.78
Rotary wing	1.00	$3,410.96

Note: RVU (relative value units), CF (conversion factor), BLS (basic life support), ALS (advanced life support).

Source: CMS.

Add-on payments

The ambulance fee schedule system incorporates several add-on payment policies tied to either the mode of ambulance transportation or the geographic location of the point of pickup. The add-on payment policies have varied between 2002 and 2013, but all of the add-on payment policies that are currently in use hinge upon CMS's geographic

categorization (urban, rural, super-rural) of the point-of-pickup ZIP code attached to each ambulance transport. Urban and rural zip codes are defined generally as those located inside (urban) or outside (rural) of a metropolitan statistical area. Super-rural ZIP codes are unique to the ambulance fee schedule and are defined as those which are located in a rural county that is among the lowest quartile of all rural counties, by population density.

The ambulance fee schedule system currently contains two permanent and three temporary add-on payment policies. The permanent add-on policies are written into law without an expiration date and include: 1) *the rural short-mileage ground ambulance add-on payment policy*, which increases the standard mileage rate by 50 percent for the first 17 miles of a ground transport if the pick-up ZIP code is rural; and 2) *the rural air transport add-on payment policy*, which reimburses providers and suppliers 50 percent more than the urban air ambulance base payment and the mileage rate if the point-of-pickup ZIP code is rural. The temporary add-on payment policies are written into law with expiration dates and include: 1) *the ground ambulance add-on payment policy*, which increases the base payment and mileage rate for ground transports by 3 percent for transports originating in rural ZIP codes and by 2 percent for transports originating in urban ZIP codes; 2) *the super-rural add-on payment policy*, which increases the base payment for ground ambulance transports by 22.6 percent where the point-of-pickup ZIP code is designated as super-rural; and 3) *the air transport rural grandfathering add-on payment policy*, which extends the benefits of the 50 percent add-on payment for air ambulance transports to urban areas that were formerly designated as rural.[3] All Medicare ambulance transports are eligible for one of the five add-on payment policies, and many are eligible for multiple add-on policies if they originate in rural ZIP codes.

The ambulance fee schedule system also contains a payment adjustment whereby a 10 percent reduction to the fee schedule payment amount is to be made to ambulance transports consisting of nonemergency basic life support transports of an individual with end-stage renal disease for renal dialysis services. This adjustment affects services furnished on or after October 1, 2013.

Updating payments

The current RVU scale remains the same in 2013 as when it was implemented in 2002.

Ambulance fee schedule payment rates are updated annually through the conversion factor and the mileage rates. The ground and air CFs, as well as the mileage rates, are updated annually by the ambulance inflation factor. This factor is an amount equal to the percentage increase in the consumer price index for all urban consumers (CPI–U) reduced by the 10-year moving average of multi-factor productivity. The update for 2013 was 0.8 percent. ■

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1 An appropriate destination can be defined as any of the following: hospital, skilled nursing facility (SNF), physician's office, freestanding or hospital-based dialysis facility, diagnostic or therapeutic service site other than a hospital or physician's office, residence, custodial care facility, intermediate stop at a physician's office on the way to the hospital, or a site of transfer between modes of ambulance transport.

2 Medicare beneficiaries served by a provider owned or operated by a critical access hospital may be responsible for more than 20 percent of the Medicare-approved amount for that service because these providers are reimbursed on the basis of reasonable cost, rather than through a prospective payment system. For a critical access hospital to be eligible for reasonable cost ambulance reimbursement, this entity must be the only supplier or provider of ambulance services within a 35-mile drive of that entity. Conversely, the beneficiary's coinsurance may be less than 20 percent if they possess medigap insurance or are dually eligible for Medicare and Medicaid.

3 In 2006, the Office of Management and Budget (OMB) changed the designation of a number of areas from rural to urban, based on updated Census data. The new designations would have ended the 50 percent add-on payment for air ambulance trips originating in the affected areas. The Medicare Improvements for Patients and Providers Act included a provision requiring these affected areas to continue to be considered rural for purposes of applying the air ambulance rural add-on payment adjustment (Section 146(b) of the Medicare Improvements for Patients and Providers Act of 2008). The provision was initially set to expire December 31, 2009, but after several extensions this provision expired on June 30, 2013.

AMBULATORY SURGICAL CENTER SERVICES PAYMENT SYSTEM

Since 1982, Medicare has covered surgical procedures provided in freestanding or hospital-operated ambulatory surgical centers (ASCs). ASCs are distinct facilities that furnish ambulatory surgery; the most common procedures in 2011 were cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures. According to preliminary estimates from the Centers for Medicare & Medicaid Services (CMS), Medicare payments to ASCs were $3.6 billion in 2012, including both program spending and beneficiary cost sharing.

In January 2008, Medicare began paying for facility services provided in ASCs—such as nursing, recovery care, anesthetics, drugs, and other supplies—using a new payment system that is primarily linked to the hospital outpatient prospective payment system (OPPS). (Medicare pays for the related physician services—surgery and anesthesia—under the physician fee schedule.) Like the OPPS, the ASC payment system sets payments for procedures using a set of relative weights, a conversion factor (or base payment amount), and adjustments for geographic differences in input prices. Beneficiaries are responsible for paying 20 percent of the ASC payment rate.

Defining the products that Medicare buys

The unit of payment in the ASC payment system is the individual surgical procedure. Each of the approximately 3,600 procedures approved for payment in an ASC is classified into an ambulatory payment classification (APC) group on the basis of clinical and cost similarity. There are several hundred APCs. All services within an APC have the same payment rate. The ASC system uses the same APCs as the OPPS.

Within each APC, CMS packages most ancillary items and services with the primary service. CMS pays separately for certain ancillary items and services when they are integral to surgical procedures:

- corneal tissue acquisition,
- brachytherapy sources,
- certain radiology services, and
- many drugs.

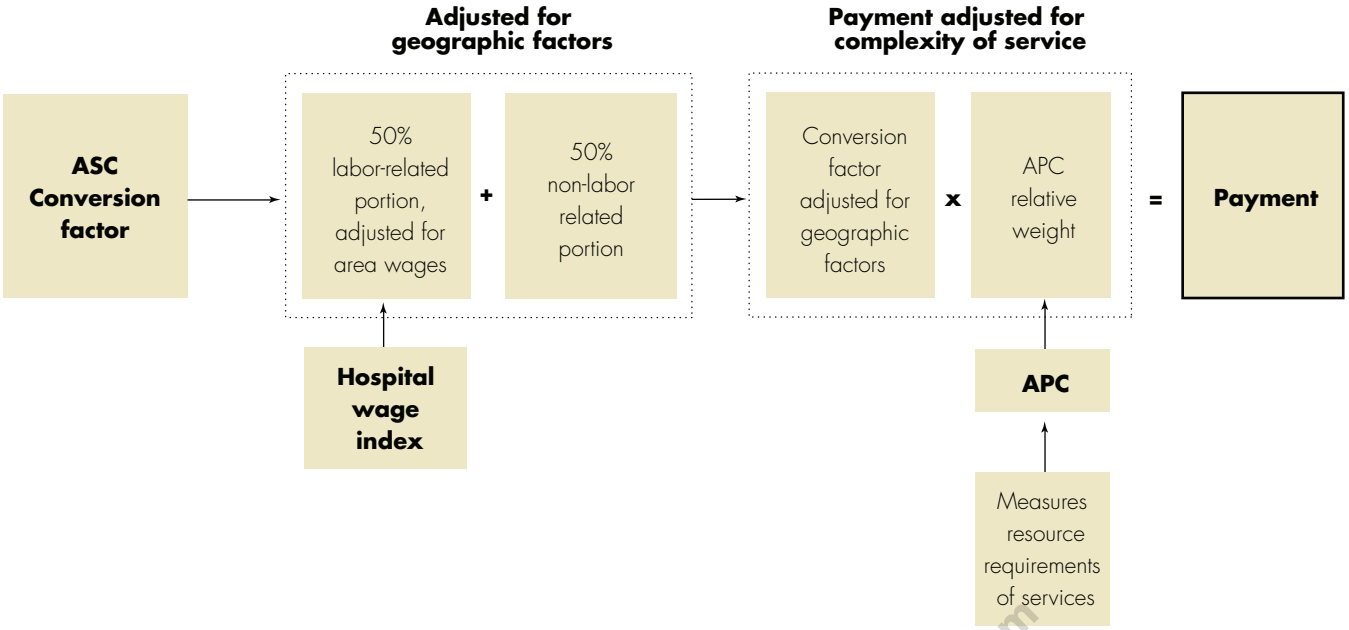
In addition, ASCs can receive separate payments for implantable devices that are eligible for pass-through payments under the OPPS. Pass-through payments are for specific, new technology items that are used in the delivery of services. The purpose of these payments is to help ensure beneficiaries' access to technologies that are too new to be well represented in the data that CMS uses to set OPPS rates.

In 2008, CMS substantially expanded the list of services that qualify for facility payment in ASCs. Medicare began paying for all procedures that do not pose a significant safety risk when performed in an ASC *and* do not require an overnight stay. CMS updates the list of approved procedures annually.

Setting the payment rates

The relative weights for most procedures in the ASC payment system are based on the relative weights in the OPPS. These weights are based on the geometric mean cost of the services in that payment group according to outpatient hospital cost data. The ASC system uses a conversion factor to translate the relative weights into dollar amounts. The ASC conversion factor is less than the OPPS conversion factor for the following reasons. First, CMS set the initial ASC conversion factor for 2008 so that total ASC payments under the new payment system would equal what

Figure 1 Ambulatory surgical center services payment system



Note: ASC (ambulatory surgical center), APC (ambulatory payment classification). The APC is the service classification system for the outpatient prospective payment system and ASC payment system. CMS uses methods different from the one shown here to set payment rates for new, office-based procedures; separately payable radiology services; separately payable drugs; and device-intensive procedures (where the cost of the device accounts for more than half of the total procedure payment). For example, payment for new, office-based procedures and separately payable radiology services equals the lower of the ASC rate (as determined by the method shown above) or the practice expense portion of the physician fee schedule payment rate that applies when the service is furnished in a physician's office.

they would have been under the previous payment system. By comparison, the initial OPPS conversion factor was based on total payments for hospital outpatient services in 2000. Second, CMS uses different update factors to account for changes in input prices for ASCs and hospitals. The 2013 ASC conversion factor is $42.92, which is 60.2 percent of the OPPS conversion factor. Consequently, the ASC rates are less than the OPPS rates.

CMS uses methods different from the one described above to set ASC payment rates for new, office-based procedures; separately payable radiology services; separately payable drugs; and device-intensive procedures. New, office-based procedures are services that CMS began paying for in ASCs in 2008 or later that are performed in physicians' offices at least 50 percent of the time. Payment is the lower of the ASC rate (based on the method described above) or the practice expense portion of the physician fee schedule rate that applies when the service is furnished in a physician's office (this amount covers the equipment, supplies, nonphysician staff, and overhead costs of a service). In capping ASC rates at physician fee schedule rates for these services, CMS seeks to minimize financial incentives to shift services from physicians' offices to ASCs. CMS applies the same policy to separately payable radiology services. When separately-payable drugs are provided in ASCs, CMS pays ASCs the same amount it pays under the OPPS.

Device-intensive procedures are defined as OPPS services for which the device cost is packaged into the procedure payment *and* the cost of the device accounts for more than half of the total payment (such as a spine infusion pump). When these procedures are provided in ASCs, CMS

divides the payment for these services into a device portion (which includes the cost of the device) and a non-device portion. CMS pays the ASC the same amount it would pay under the OPPS for the device portion of the service but pays 60.2 percent of the OPPS amount for the non-device portion of the service.

To account for geographic differences in input prices, CMS adjusts the labor portion of the ASC rate (50 percent) by the hospital wage index. CMS does not adjust the non-labor portion (the remaining 50 percent). A survey of ASCs conducted by the Government Accountability Office determined that labor accounts for about 50 percent of ASC costs.

As in the OPPS, ASC payment rates are adjusted when multiple surgical procedures are performed during the same encounter. In this case, the ASC receives full payment only for the procedure with the highest payment rate; payments for the other procedures are reduced to one-half of their usual rates.

CMS updates the ASC relative weights annually based on changes to the OPPS relative weights and the physician fee schedule practice expense amounts. Because the OPPS relative weights usually change each year by a small amount, CMS adjusts the new OPPS weights so that projected program spending based on the current mix of services does not change. However, the mix of services in ASCs differs from that of hospital outpatient departments. Therefore, using the new OPPS relative weights could increase or decrease total ASC spending. To ensure that ASC spending does not change as a result of the new weights, CMS adjusts each ASC relative weight by the same scaling factor. In 2013, this factor reduced the ASC relative weights by 6.8 percent below the OPPS weights. This scaling factor does not apply to items and services that are paid separately, such as separately-paid drugs.

In 2013, the ASC conversion factor was increased by 0.6 percent, based on a 1.4 percent increase in the consumer price index for all urban consumers (CPI–U), which CMS uses to update ASC rates, minus a 0.8 percent deduction for multifactor productivity growth. The Patient Protection and Affordable Care Act of 2010 requires that, beginning in 2011, the annual update for ASC services (based on the CPI–U) must be reduced each year by multifactor productivity growth. ■

CLINICAL LABORATORY SERVICES PAYMENT SYSTEM

Medicare is the largest single purchaser of clinical laboratory services. Clinical lab services are tests on specimens taken from the human body (such as blood or urine) that are used to diagnose and treat patients. Under Part B, Medicare covers medically reasonable and necessary laboratory services that are ordered by a physician or a qualified nonphysician practitioner when they are provided in a lab that is certified by the Centers for Medicare & Medicaid Services (CMS). With a few exceptions, Medicare does not cover routine screening tests unless directed to by law. Covered screening tests (with some restrictions) include cardiovascular screening tests, colorectal cancer screening tests, Pap smear tests, and prostate-specific antigen tests.

The majority of lab services do not involve the work of a physician; these services are paid under the Clinical Laboratory Fee Schedule (CLFS). Lab services that include physician work, such as surgical pathology, are paid under the fee schedule for physicians and other health professionals. This payment basics document describes the CLFS. A separate document, *Medicare Payment Basics: Physician and Other Health Professionals Payment System,* describes the fee schedule for physicians and other health professionals.

Clinical lab services are furnished by labs located in hospitals and physician offices, as well as by independent labs. Services may also be furnished by labs located in dialysis facilities, nursing facilities, and other institutions, but frequently these tests are paid under other Medicare payment systems.

Medicare spending for lab services under the CLFS grew by an average of 5.6 percent per year between 2003 and 2012. This growth was primarily driven by rising volume as there were very few increases in payment rates during those years. Spending was flat in 2011 but grew by 9.1 percent in 2012. In 2012, Medicare payments for clinical lab services totaled $9.7 billion, 1.7 percent of total Medicare spending.

To pay for lab services, Medicare uses 56 carrier-specific fee schedules established in 1984. Payment rates for each test were set separately in each carrier's geographic region, based on what local labs charged at the time; since 1984, the rates have been updated periodically for inflation and other statutory adjustments. In addition, there are national payment limits that cap the fee schedule rates for each test. In practice, most lab claims are paid at the national payment limits.

Defining the product Medicare buys

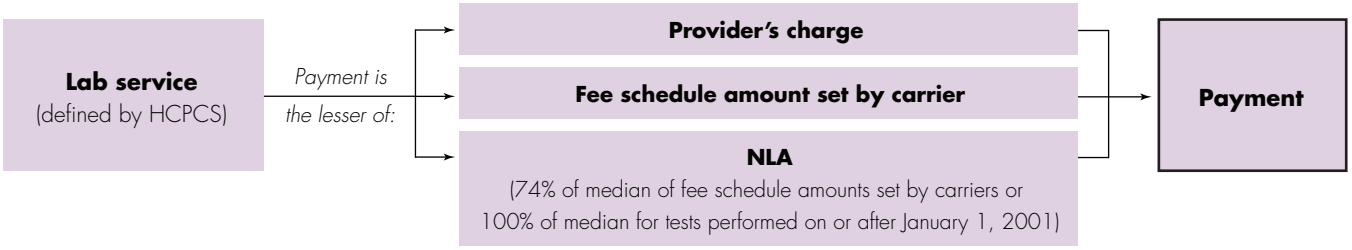
Medicare sets payment rates for more than 1,250 Healthcare Common Procedure Coding System (HCPCS) codes used in the CLFS. A single HCPCS code may identify more than one testing method for a given substance or more than one substance analyzed by a single method.

Setting the payment rates

There is no beneficiary cost sharing for clinical lab services; therefore, the CLFS payment rates are the total payment laboratories receive for their services. Because each carrier established its own fee schedule based on charges from the laboratories in its region, fee schedule amounts may differ by region. CMS has transitioned from 56 carrier localities to 15 Medicare administrative contractor (MAC) jurisdictions. MACs continue to maintain the 56 different fee schedules established by carriers.

Beginning in 1986, the Congress established national limits on laboratory payment rates, called national limitation amounts (NLAs). The NLAs are set at 74 percent of the median of all carrier fee schedule amounts for each service (or 100 percent of the median for new tests performed on or after January 1, 2001). The payment for each service is the lesser of the provider's charge, the carrier's fee schedule amount, or the NLA (Figure 1).

Figure 1 Clinical laboratory services payment system



Note: HCPCS (Healthcare Common Procedure Coding System), NLA (national limitation amount). The majority of claims are paid at the NLA. Carriers were the CMS contractors that were responsible for reviewing and paying Medicare claims. Carriers have been replaced by Medicare administrative contractors.

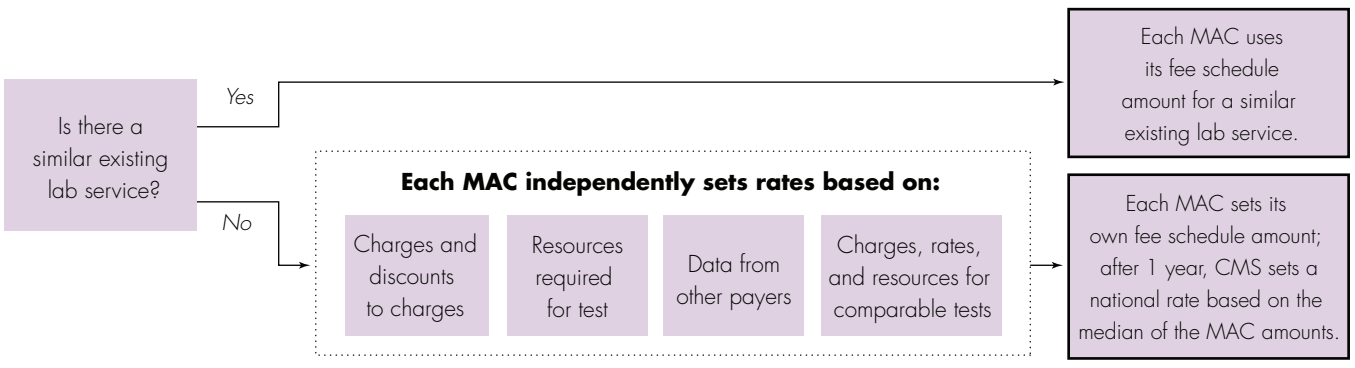
Because so many of the carrier payment rates are constrained by the NLAs, most lab services are paid the same national rate. Unlike most other Medicare services, payment rates for lab tests are not adjusted for geographic differences in input prices.

Initially, lab payments were adjusted for inflation annually using the consumer price index for all urban consumers (CPI–U), but since 1987 the Congress has specified lower updates. For 2011 through 2015, the statute requires that the CPI–U update be reduced by a multi-factor productivity adjustment (MFP) and by a further 1.75 percentage points. In 2013, the statute requires that the update be reduced by 2 percentage points, in addition to the MFP reduction and 1.75 percentage point reduction. The net update for 2013 is –2.95 percent (the CPI–U of 1.7 percent was reduced by the MFP of 0.9 percent, 1.75 percentage points, and 2.0 percentage points).

When labs begin using newly developed tests, CMS uses a "crosswalking" method to assign payment rates based on their similarity to existing tests (Figure 2). For break-through technologies for which there are no similar existing tests, CMS relies on a "gapfilling" method in which the MACs independently set rates for the first year of use. Each MAC researches and sets its own payment amount based on charges for the test and discounts to charges; resources required to perform the test; data from other payers; and charges, rates, and resources used for comparable tests. After one year, CMS sets the national rate at the median of the MAC rates. CMS uses the crosswalking method more frequently than the gapfilling method to set rates for new lab tests. After one year, CMS may reconsider both the payment method (crosswalking or gapfilling) and national payment amount for a new test. There is currently no mechanism for reviewing payment rates for existing tests.

Unlike other providers of outpatient clinical laboratory tests, critical access hospitals are paid for laboratory tests on a reasonable cost basis, instead of under the lab fee schedules. ■

Figure 2 Setting fee schedule amounts for a new clinical lab service



Note: MAC (Medicare administrative contractor). MACs are CMS contractors that are responsible for reviewing and paying Medicare claims.

CRITICAL ACCESS HOSPITALS PAYMENT SYSTEM

Medicare beneficiaries can receive care in over 1,300 small hospitals called critical access hospitals (CAHs). CAHs are limited to 25 beds and primarily operate in rural areas. Unlike traditional hospitals (which are paid under prospective payment systems), Medicare pays CAHs based on each hospital's reported costs. Each CAH receives 101 percent of its costs for outpatient, inpatient, laboratory and therapy services, as well as post-acute care in the hospital's swing beds.[1]

In addition to 25 acute beds, CAHs are allowed to have distinct-part skilled nursing facilities, 10-bed psychiatric units, 10-bed rehabilitation units, and home health agencies. However, these departments of the CAH are paid through Medicare's prospective systems and are not eligible for cost-based reimbursement.

History of the CAH program

In 1988, the Montana Hospital Research and Education Foundation designed a demonstration of a type of hospital called a medical assistance facility (MAF) that received cost-based reimbursement from Medicare. MAFs were isolated, limited-service hospitals that could admit patients for no more than a four-day length of stay. In 1989, the Congress authorized the Rural Primary Care Hospital (RPCH) program, a second demonstration program whereby small, rural hospitals would receive cost-based payments from Medicare. In 1997, the Balanced Budget Act of 1997 merged the MAF and RPCH programs into a new category of hospitals called critical access hospitals. CAHs would receive cost-based inpatient and outpatient payments from Medicare.

To qualify for the CAH program, a hospital had to be at least 15 miles by secondary road and 35 miles by primary road from the nearest hospital or be declared a "necessary provider" by the state. Because states could waive the distance requirement, the CAH program became an option for almost all small rural hospitals, as opposed to being limited to helping isolated hospitals. Approximately 65 percent of CAHs are between 15 and 35 miles from the nearest hospital. However, some are less than 5 road miles from another hospital and others (approximately 20 percent of CAHs) are more than 35 road miles from an alternative source of emergency care.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated states' ability to declare additional hospitals "necessary providers" starting in January 2006. As a result, CMS has authorized few additional CAHs since 2006 because most hospitals that meet the distance and size criteria have already converted to CAH status. Current CAHs will retain their CAH status, even if they do not meet the distance criteria.

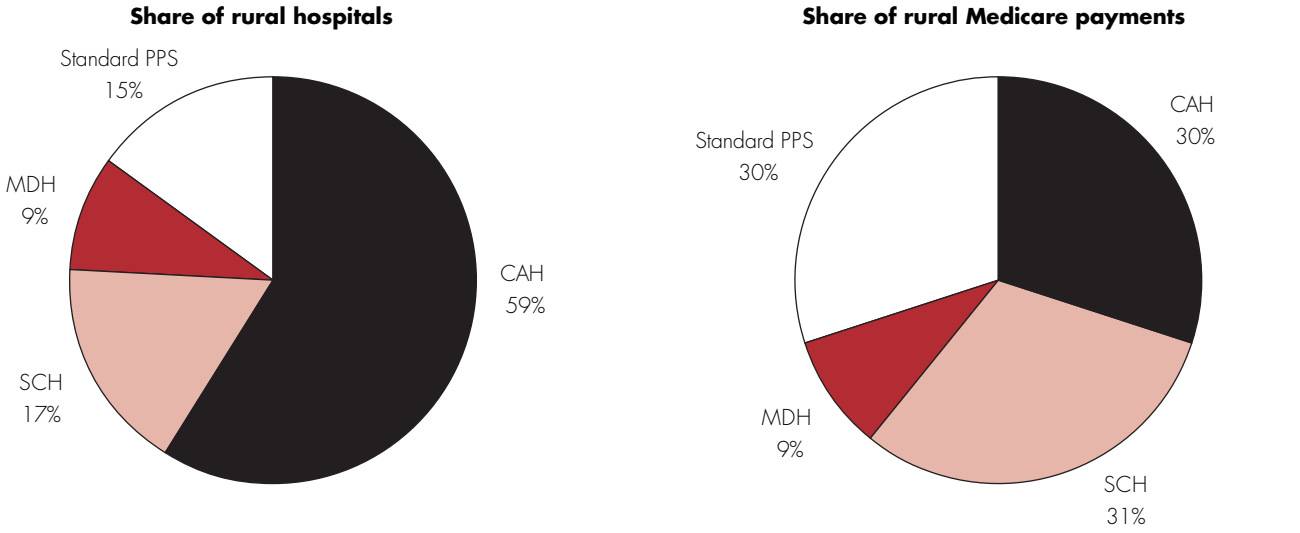
Defining the care that Medicare buys from CAHs

Medicare pays for the same services from CAHs as from other acute care hospitals (e.g., inpatient stays, outpatient visits, laboratory tests, and post-acute skilled nursing days). However, CAHs' payments are not based on the type of service provided or the number of services provided. Payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients.

Computing Medicare payments

Medicare pays CAHs 101 percent of their allowable costs for most services. The cost of treating Medicare patients is estimated using cost accounting data from Medicare cost reports. CMS's cost accounting methodology allocates costs among patients based on a combination of factors such as the number of days a patient stays in the hospital and the dollar value of charges

Figure 1 Share of hospitals and Medicare payments by rural hospital type



Note: CAH (critical access hospital), SCH (sole community hospital), MDH (Medicare-dependent hospital), PPS (prospective payment system). Payments are from 2010 Medicare cost reports. Standard PPS refers to hospitals paid under the traditional PPS payment rates and includes rural referral centers that are not SCHs or MDHs. Percentages may not add to 100 percent due to rounding.

the patient incurs for ancillary services. Beneficiaries pay the standard hospital deductible for inpatient services and cost sharing equal to 20 percent of charges (not costs) for outpatient services.

Medicare's cost-based payments to CAHs (including beneficiary cost sharing) were over $8 billion in 2011, representing 5 percent of all Medicare inpatient and outpatient payments to hospitals.

Differences between CAH, SCH, and MDH Medicare payments

As Figure 1 illustrates, most rural hospitals are either CAHs (59 percent), sole community hospitals (SCHs) (17 percent), or Medicare-dependent hospitals (MDHs) (9 percent). These hospitals receive a majority of rural inpatient Medicare payments. "Cost-based payments" provided to CAHs differ from "cost-based payments" paid to SCHs and MDHs. SCHs receive the higher of either (a) standard inpatient prospective payment rates or (b) payments based on the hospital's costs in a base year updated to the current year and adjusted for changes in their case mix. MDHs are similar to SCHs, but they are eligible for a prospective payment rate based on a blend of current PPS rates (25 percent) and their historical costs (75 percent). The SCH and MDH payment methodology differs in two significant ways from CAH cost-based payments. First, SCHs and MDHs only receive cost-based payments for inpatient care; CAHs receive cost-based payments for inpatient, outpatient, lab, therapy, and post-acute services in swing beds. Second, SCHs' and MDHs' payments are based on historical costs trended forward. Therefore, if a SCH or MDH increases its expenditures per patient, its payments will not be affected. In contrast, if a CAH increases its expenditures per patient, Medicare payments increase accordingly.

To qualify for the SCH program, a hospital must be located at least 35 miles from the nearest like hospital (excluding CAHs), or meet other federal criteria for being deemed a community's sole source of care. To qualify for MDH designation, a facility must be located in a rural area, have no more than 100 beds, not be classified as an SCH, and have at least 60 percent of inpatient days or discharges attributable to Medicare patients. ■

1 Most CAH beds are "swing beds", which can be used for acute or post-acute care. In some states, these beds can also be used for long-term care of Medicaid patients.

DURABLE MEDICAL EQUIPMENT PAYMENT SYSTEM

Medical equipment needed at home to treat a beneficiary's illness or injury is covered under the durable medical equipment (DME) benefit. Medicare spent about $8.4 billion on DME in calendar year 2012. Oxygen and related supplies has been the largest category of DME, representing about a quarter of DME spending in recent years.

Wheelchairs and respirators are typical of the equipment Medicare pays for under this benefit. To be covered, the equipment must:

- withstand repeated use,
- primarily serve a medical purpose, and
- generally not be useful to a person without an illness or injury.

Thus, expendable supplies, such as bandages or incontinence pads, or otherwise useful equipment such as a humidifier, would not be covered under this benefit.

Medicare also covers prosthetics, orthotics, and some medications under its DME benefit. Covered prosthetics generally are artificial limbs; orthotics include orthopedic braces and some supportive garments. Medication that is necessary to the function performed by durable equipment is also covered under this benefit—for example, heparin administered in a home dialysis system or albuterol in a nebulizer.

Beneficiaries are responsible for 20 percent coinsurance.

Supplier enrollment safeguards have been progressively strengthened. Accreditation and surety bonds were required in 2009, and licensure and physical space requirements—among others—were added effective September 27, 2010.

The equipment Medicare buys

Medicare uses fee schedules to set prices for noncustomized equipment, prosthetics, and orthotics. These items are assigned to categories and to product groups within those categories. The categories are based on the nature of the item: whether or not it is inexpensive, needs frequent service, or is a rental item subject to an explicitly limited period of use. The categories are:

- inexpensive or routinely purchased equipment,
- items requiring frequent and substantial servicing,
- prosthetic and orthotic devices,
- capped rental items, and
- oxygen and oxygen equipment.

Within the categories, items are further categorized into about 2,000 product groups. Examples of product groups are high-strength lightweight wheelchairs and rental portable oxygen systems. All items within the same product group have the same payment rate.

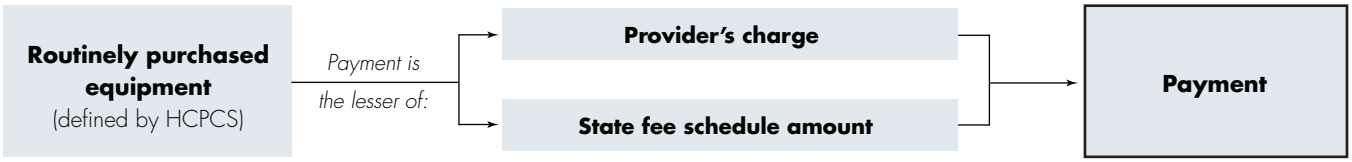
Setting the payment rates

Generally, the current fees are an average of the allowed charges from 1986 and 1987, adjusted by the consumer price index for all urban consumers to account for inflation. Several exceptions to this general rule are:

- Customized equipment and medications are paid at rates that are determined item by item, by the regional carrier.
- Prices for most medications used in conjunction with DME are set at 106 percent of the average sales price (ASP). Infusion drugs administered with an external pump are paid at 95 percent of the October 1, 2003, average wholesale price (AWP).
- Prices for home oxygen are based on the median 2002 Federal Employee Health Benefit plan price.

To capture geographic differences in prices for equipment, Medicare uses a separate fee schedule for each state. The program pays the lesser of the provider's charge and the state fee schedule amount (Figure 1). State fee schedule rates are subject to a national floor and ceiling to limit the variability in prices across

Figure 1 Durable medical equipment payment system



Note: HCPCS (Healthcare Common Procedure Coding System).

the country. The fees for prosthetics and orthotics are also determined state by state but are subject to regional limits. There are no state or regional variations in the price of drugs that Medicare purchases through this benefit. The applicable fee schedule is determined by the location of beneficiaries' residences rather than the location of the DME provider.

Competitive bidding

Qualified suppliers were allowed to bid against one another to test a new method of pricing and purchasing DME in two areas between 2000 and 2002. As an incentive to compete, suppliers whose bids were not among the lowest priced were excluded from the market or not allowed to serve new clients. In that demonstration, competitive bidding lowered prices for selected DME items between 17 and 22 percent. Analyses of the demonstration did not find serious quality or access issues.

As mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), a competitive bidding process for DME was to be phased in nationwide, starting with 10 metropolitan statistical areas (MSAs) in 2008 and expanding to 80 MSAs by 2009. Contracts to supply DME in ten product categories (e.g., oxygen, hospital beds) were to be awarded to the winning bidders.

The first round of competition took place and contracts were awarded and took effect July 1, 2008. CMS estimated that the program and beneficiaries would save an average of 26 percent on the competitively bid items.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) terminated the contracts awarded in Round 1, delayed the competitive bidding process, authorized a national mail-order program for diabetic testing supplies, and made several other changes to the program. To offset the cost of delaying the program, the fee schedule amount for any item selected for competitive acquisition before July 1, 2008, was not increased by the scheduled amount and was instead reduced by 9.5 percent nationwide in 2009. The new first round of competition began in October 2009. It excluded one MSA from the original ten and excluded the negative pressure wound therapy product category from the original ten product categories subject to competitive bidding. The new contracts and single payment rates for each MSA went into effect January 2011. In the first year of implementation CMS estimates savings of about $200 million, or 42 percent less than would have been paid under the fee schedule. Of this reduction in spending, 35 percent is due to lower prices paid by Medicare, and 7 percent due to lower volume. CMS reports there have been no major issues with beneficiary access in those areas.

The second round of competition started in 2011 in 91 additional MSAs. Round 2 of the competitive bidding program and the national mail-order program for diabetic testing supplies went into effect July 1, 2013. CMS estimates prices will be 45 percent lower for items in the Round 2 areas and 72 percent lower for mail order diabetic supplies nationwide. ■

HOME HEALTH CARE SERVICES PAYMENT SYSTEM

Beneficiaries who are generally restricted to their homes and need skilled care (from a nurse, physical, or speech therapist) on a part-time or intermittent basis are eligible to receive certain medical services at home. Home health agency (HHA) personnel visit beneficiaries' homes to provide services:

- skilled nursing care,
- physical, occupational, and speech therapy,
- medical social work, and
- home health aide services.

Beneficiaries are not required to make any copayments or other cost sharing for these services.

About 3.4 million beneficiaries used home health care in 2011. Medicare pays for home health care with both Part A and Part B funds; in 2011, total payments were $18.4 billion. Over 12,000 agencies participated in the program in 2011.

In October 2000, CMS adopted a prospective payment system (PPS) that pays HHAs a predetermined rate for each 60-day episode of home health care. The payment rates are based on patients' conditions and service use, and they are adjusted to reflect the level of market input prices in the geographical area where services are delivered. If fewer than 5 visits are delivered during a 60-day episode, the HHA is paid per visit by visit type, rather than by the episode payment method. Adjustments for several other special circumstances, such as high-cost outliers, can also modify the payment.

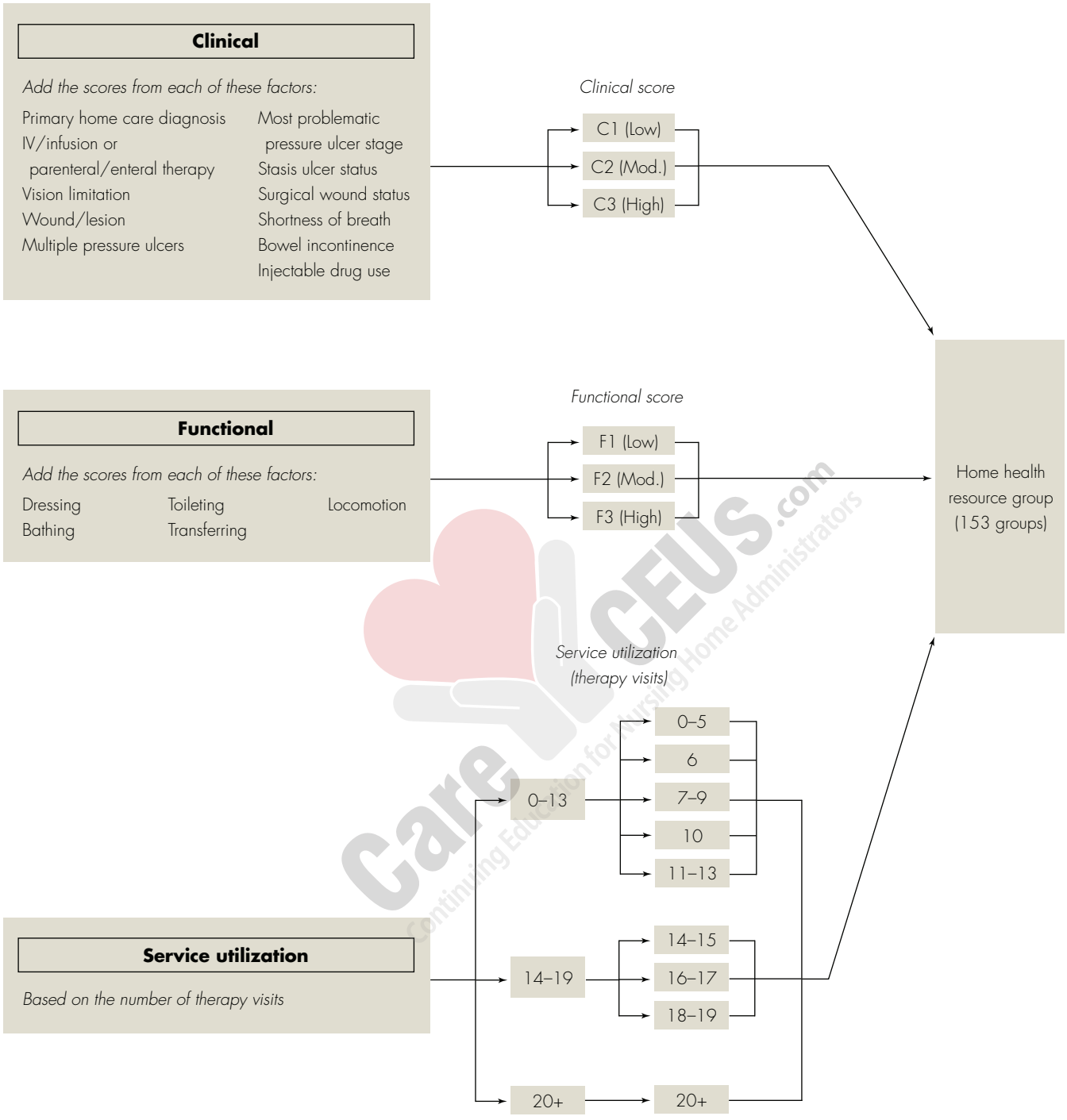
Setting rates for Medicare home health services has always been complicated by the lack of a clear definition of the benefit. The benefit was originally intended for short-term, post-hospital recovery care for beneficiaries who could not leave their homes, but changes to eligibility criteria have expanded the benefit. Originally the benefit had more restrictive coverage standards, such as requiring a prior hospital stay or limiting the number of visits allowed. These limitations were eliminated, and a beneficiary can receive an unlimited number of episodes as long as they meet the other coverage criteria.

The care Medicare buys

Medicare purchases home health services in units of 60-day episodes. To capture differences in expected resource use, patients receiving 5 or more visits are assigned to 1 of 153 home health resource groups (HHRGs) based on clinical and functional status and service use as measured by the Outcome and Assessment Information Set (OASIS) (Figure 1). The information presented in this document applies to the 2012 home health payment year.

The 153 HHRGs are divided into 5 categories based on the amount of therapy provided and the episode's timing in a sequence of episodes. Four of the categories are based on a combination of whether the episode is an early episode (first or second episode) or late episode (third and subsequent episode) and whether the episode has zero to 13 therapy visits or 14 to 19 visits. A fifth separate category exists for episodes that have 20 or more therapy visits, and it is not affected by episode timing. These separate categories permit the case-mix system to differentiate between the resource use of different levels of therapy utilization and multiple episodes. The system is calibrated to provide higher payments for later episodes in a sequence of consecutive episodes (third and subsequent episodes), and raises payment as therapy visits increase.

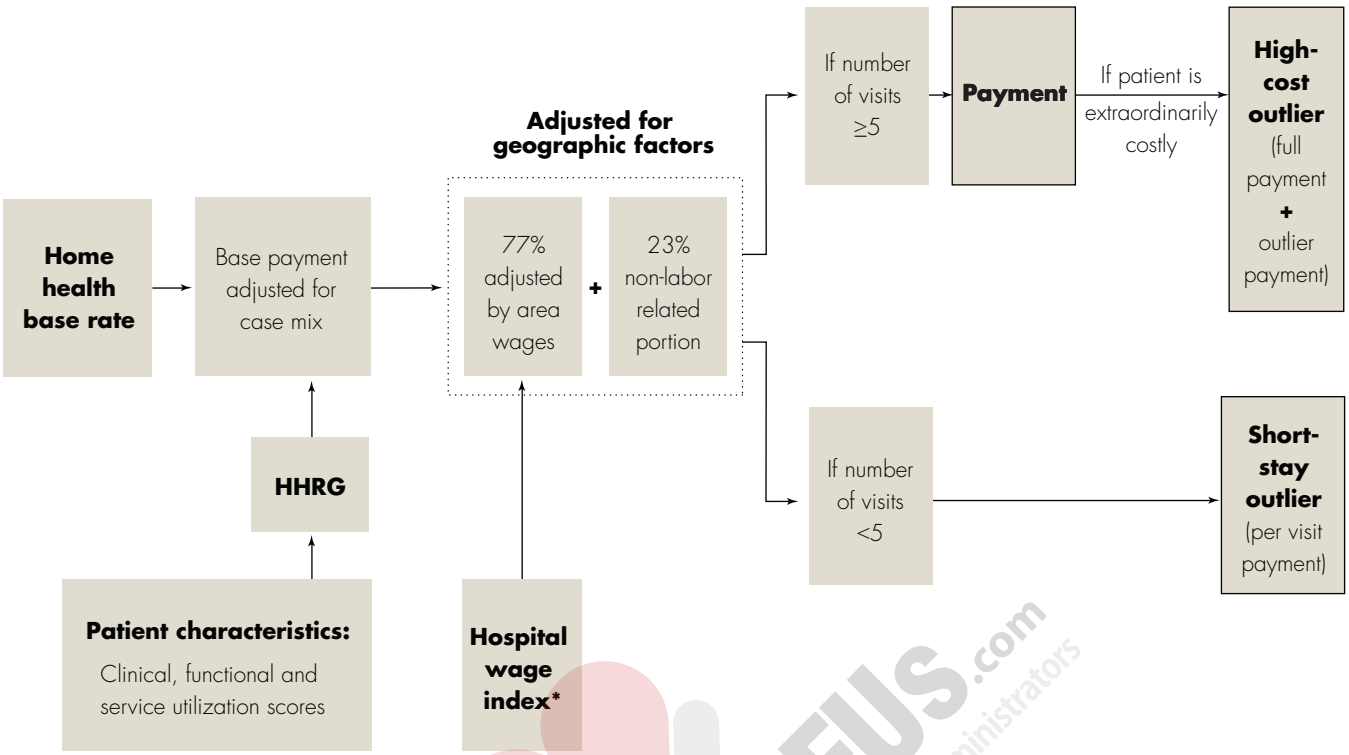
Figure 1 Clinical, functional, and service information from OASIS determines patients' home health resource group



Note: OASIS (Outcome and Assessment Information Set), IV (intravenous).

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2008. Medicare program; Home health prospective payment system rate update for calendar year 2009. Final rule. *Federal Register* 73, no. 213 (November 3): 65351–65384.

Figure 2 Home health care services prospective payment system



Note: HHRG (home health resource group).
*The home health care services prospective payment system uses a version of the hospital wage index called the 'pre-floor, pre-classification hospital wage index.'

Setting the payment rates

The HHRGs range from groups of relatively uncomplicated patients to those of patients who have severe medical conditions, severe functional limitations, and need extensive therapy. Each HHRG has a national relative weight reflecting the average relative costliness of patients in that group compared with the average Medicare home health patient. The payment rates for episodes in each local market are determined by adjusting a national average base amount—the amount that would be paid for a typical home health patient residing in an average market—for geographic factors and case mix (Figure 2). The base payment amount for 2013 is $2,137.73.

To adjust for geographic factors, the per episode payment rate is divided into labor and non-labor portions; the labor portion—77 percent—is adjusted by a version of the hospital wage index to account for geographic differences in the input-price level in the local market for labor-related inputs to home health services. Unlike most other Medicare payment systems, the local area adjustment for home health services is determined by the beneficiary's residence rather than the provider's location. The total payment is the sum of the adjusted labor portion and the nonlabor portion. The Patient Protection and Affordable Care Act included an add-on payment of 3 percent for episodes provided in rural areas, effective for services provided from April 2010 through 2015.

To adjust for case mix, the base rate is multiplied by the relative weight for each HHRG.

When a patient's episode of care involves an unusually large number or a costly mix

of visits, the HHA may be eligible for an outlier payment. To be eligible, imputed episode costs must exceed the payment rate by a certain amount set annually by CMS.[1] To determine eligibility for an outlier payment, episode costs are imputed by multiplying the estimated national average per visit costs by type of visit—adjusted to reflect local input prices—by the numbers of visits by type during the episode. When these estimated costs exceed the outlier threshold, the HHA receives a payment equal to 80 percent of the difference between the episode payment with the threshold and the episode's estimated costs.

The PPS also adjusts payments for nonroutine medical supplies (e.g., wound-related products). The payment is based on the beneficiary's estimated use of nonroutine supplies, based on the clinical and functional characteristics on the OASIS.

The base rate is updated annually. The update is based on the projected change in the home health market basket, which measures changes in the prices of goods and services bought by home health agencies. For 2012 the update was reduced by 1 percentage point, for a payment update of 1.5 percent. However, this update was further lowered by 3.79 percent, to adjust for changes in agencies' reported case mix that CMS concluded were unwarranted. ■

1 The amount equaled 0.45 times the standard base payment amount in 2013 adjusted by the wage index.

HOSPICE SERVICES PAYMENT SYSTEM

The Medicare hospice benefit covers a broad set of palliative services for beneficiaries who have a life expectancy of six months or less, as determined by their physician. Beneficiaries who elect the Medicare hospice benefit agree to forgo curative treatment for their terminal condition. For conditions unrelated to their terminal illness, Medicare continues to cover items and services outside of hospice. Typically, hospice care is provided in patients' homes, but hospice services may also be provided in nursing facilities and other inpatient settings. Hospice providers can be freestanding entities or based in hospitals, skilled nursing facilities, or home health agencies.

CMS data show rapid growth in use of the hospice benefit among Medicare beneficiaries and associated program spending. The number of beneficiaries using hospice more than doubled between 2000 and 2011, exceeding 1.2 million in 2011. The total number of providers has also increased. The number of hospice agencies participating in the Medicare program increased by 59 percent from 2000 to 2011. In addition, as of 2011, about 57 percent of hospice agencies were for profit, compared to about 30 percent in 2000. Medicare payment for hospice grew from almost $3 billion in 2000 to $13.8 billion in 2011.

The hospice product and Medicare payment

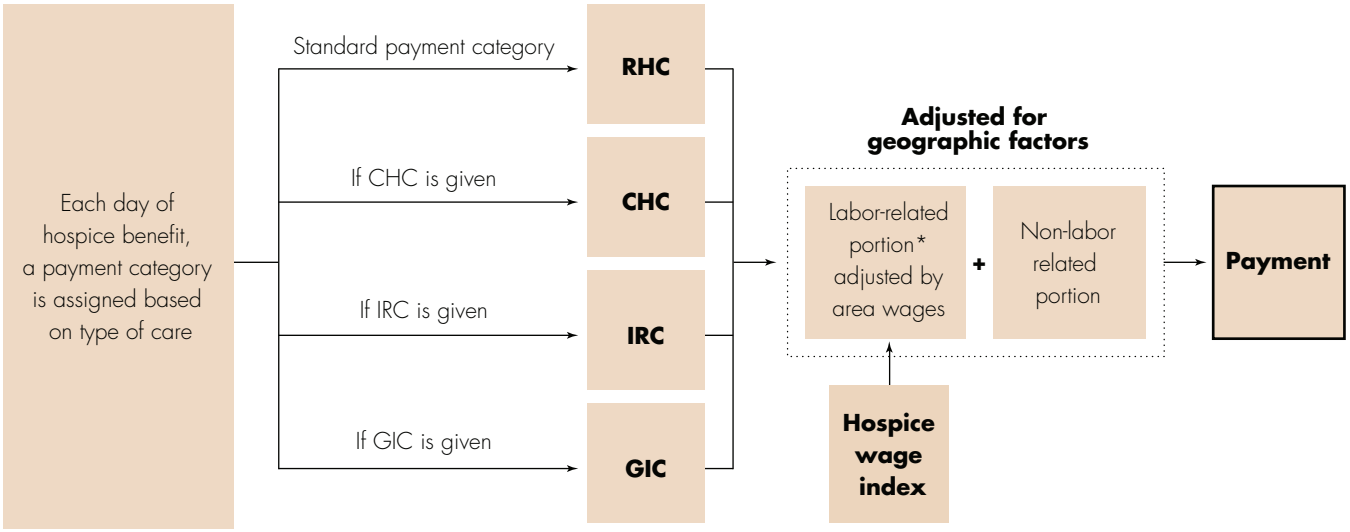
The hospice benefit is designed to provide pain relief, comfort, and emotional and spiritual support to patients with a terminal diagnosis. To provide this type of care, the benefit covers an array of services, such as:

- skilled nursing services;
- drugs and biologicals for pain control and symptom management;
- physical, occupational, and speech therapy;
- counseling (dietary, spiritual, family bereavement, and other counseling services);
- home health aide and homemaker services;
- short-term inpatient care;
- inpatient respite care; and
- other services necessary for the palliation and management of the terminal illness.

Setting the payment rates

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit (Figure 1). Medicare makes a daily payment, regardless of the amount of services provided on a given day and on days when no services are provided. The daily payment rates are intended to cover costs that hospices incur in furnishing services identified in patients' care plans. Payments are made according to a fee schedule that has four base payment amounts for the four different categories of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC) (Table 1). The payment rates are updated annually based on the hospital market basket index, which beginning in fiscal year 2013 is reduced by a productivity adjustment (as required by the Patient Protection and Affordable Care Act of 2010). An additional reduction to the market basket update of 0.3 percentage points was required in 2013 and 2014 and possibly in the years 2015 through 2019 if certain targets for health insurance coverage among the working age population are met. Payments to hospices that do not report specified quality data are reduced by 2 percentage points beginning in fiscal year 2014.

Figure 1 Hospice prospective payment system



Note: RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care).
*The labor-related portion adjusted by the wage index varies, depending on payment category (see Table 1). Wage index adjustment is based on the location of the patient, not the hospice agency.

The four categories of care are distinguished by the location and intensity of the services provided, and the base payments for each category reflect variation in expected input cost differences. Unless a hospice provides CHC, IRC, or GIC on any given day, it is paid at the RHC rate. For any given patient, the type of care can vary throughout the hospice stay as the patient's needs change. More than 95 percent of days of hospice care provided are at the routine home care level.

The daily hospice payment rates are adjusted to account for differences in

Table 1 Hospice payment categories and rates

Category of care	Description	Base payment rate, FY 2014	Labor-related portion of payment adjusted by the wage index, FY 2014
RHC	Home care provided on a typical day	$156	69%
CHC	Home care provided during periods of patient crisis	911	69
IRC	Inpatient care for a short period to provide respite for primary caregiver	161	54
GIC	Inpatient care to treat symptoms that cannot be managed in another setting	694	64

Note: FY (fiscal year), RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care). Payment for CHC is an hourly rate ($910.78=24 hours of care at $37.95 per hour) for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. In addition, a nurse must deliver half of the hours of this care to qualify for CHC-level payment. The above rates apply to hospices that submit the required quality data. The rates are 2 percentage points lower for hospices that do not submit the required quality data.

Source: CMS Manual System Pub 100–04 Medicare Claims Processing, Transmittal 2766, "Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, Quality Reporting Program, and the Hospice Pricer for FY 2014." August 16, 2013.

wage rates among markets. Each category of care's base rate has a labor share and a non-labor share; those amounts differ across each category, reflecting the estimated proportion of each rate that is attributable to wage and non-wage costs. The labor share of the base payment amount is adjusted by the hospice wage index for the location in which care is furnished and the result is added to the non-labor portion.

From 1983 to 1997, Medicare adjusted hospice payments using a 1983 wage index, based on 1981 Bureau of Labor Statistics data. In fiscal year 1998, after a negotiated rulemaking process, CMS began using the most current hospital wage index to adjust hospice payments, and applied a budget neutrality adjustment each year to make aggregate payments equivalent to what they would have been under the 1983 wage index. This budget neutrality adjustment increased Medicare payments to hospices by about 4 percent. In fiscal year 2010, CMS began phasing out the budget neutrality adjustment over seven years, reducing it by 0.4 percentage points in 2010 and by an additional 0.6 percentage points each subsequent year until it is eliminated entirely in 2016.

Two caps limit the amount and cost of care that any individual hospice agency provides in a single year. One cap limits the number of days of inpatient care an agency may provide to not more than 20 percent of its total patient care days. The other cap is an absolute dollar limit on the average annual payment per beneficiary a hospice can receive. If a hospice's total payments exceed its total number of Medicare patients multiplied by $26,157.50 in the year ending October 31, 2013, it must repay the difference. Unlike the daily rates, this cap is not adjusted for geographic differences in costs. The hospice cap is adjusted annually by the medical expenditure category of the consumer price index for all urban consumers.

Hospice payments were calculated based on information from a Medicare demonstration project completed in the early 1980s. The program has not examined the set of services included in the payment since then to reflect changes in patterns of hospice care and associated costs.

Beneficiary liability for hospice services is minimal. Hospices may charge a 5 percent coinsurance for each drug furnished outside of the inpatient setting, but the coinsurance may not exceed $5 per drug. For inpatient respite care, beneficiaries are liable for 5 percent of Medicare's respite care payment per day. Beneficiary coinsurance for respite care may not exceed the Part A inpatient hospital deductible, which was $1,184 in 2013. ■

HOSPITAL ACUTE INPATIENT SERVICES PAYMENT SYSTEM

Medicare beneficiaries enrolled in the traditional fee-for-service program receive care in over 3,500 facilities that contract with Medicare to provide acute inpatient care and agree to accept the program's predetermined payment rates as payment in full.[1] Payments made under the acute inpatient prospective payment system (IPPS) totaled $117 billion and accounted for about 25 percent of Medicare spending in 2011. These payments provide about 20 percent of hospitals' overall revenues.

Medicare's inpatient hospital benefit covers beneficiaries for 90 days of care per episode of illness, with a 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted and end after they have been out of the hospital or a skilled nursing facility for 60 consecutive days. In 2013, beneficiaries are liable for a deductible of $1,184 for the first hospital stay in an episode, and daily copayments—currently $296—are imposed beginning on the 61st day.

As outlined in Figure 1, the IPPS pays per discharge rates that begin with two national base payment rates—covering operating and capital expenses—which are then adjusted to account for two broad factors that affect hospitals' costs of furnishing care:

- the patient's condition and related treatment strategy, and
- market conditions in the facility's location.

To account for the patient's needs, Medicare assigns discharges to Medicare severity diagnosis related groups (MS–DRGs), which group patients with similar clinical problems that are expected to require similar amounts of hospital resources. Each MS–DRG has a relative weight that reflects the expected relative costliness of inpatient treatment for patients in that group. To account for local market conditions, the payment rates for MS–DRGs in each local market are determined by adjusting the national base payment rates to reflect the relative input-price level in the local market. In addition to these two factors, the operating and capital payment rates are increased for facilities that operate an approved resident training program or that treat a disproportionate share of low-income patients. Conversely, rates are reduced for certain transfer cases, and outlier payments are added for cases that are extraordinarily costly.

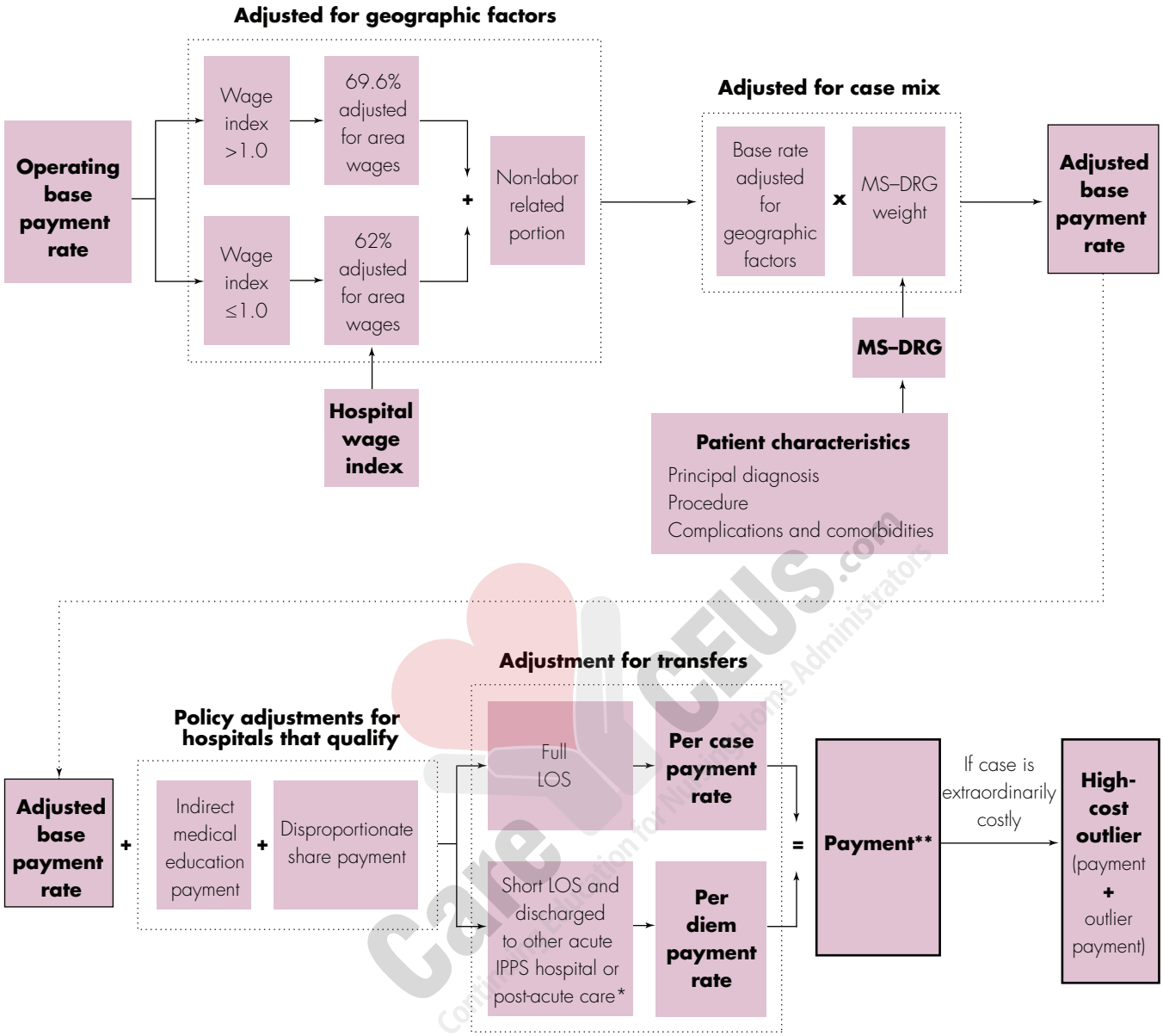
The IPPS payment rates are intended to cover the costs that reasonably efficient providers would incur in furnishing high-quality care.

Defining the inpatient acute care products Medicare buys

Under the IPPS, Medicare sets per discharge payment rates for 751 severity-adjusted MS–DRGs, which are based on patients' clinical conditions and treatment strategies. Clinical conditions are defined by both the patients' discharge diagnoses, including the principal diagnosis—the main problem requiring inpatient care—and up to eight secondary diagnoses indicating other conditions that were present at admission (comorbidities) or developed during the hospital stay (complications). The treatment strategy—surgical or medical—is defined by the presence or absence of up to six procedures performed during the stay.

The MS–DRG system has 335 base DRGs, most of which are split into 2 or 3 MS–DRGs based on the presence of either a comorbidity or complication (CC) or major CC. Discharge destination and use of a specific drug are occasionally used along with principal diagnosis and procedures in structuring base DRGs.

Figure 1 Acute inpatient prospective payment system



Note: MS–DRG (Medicare severity diagnosis related group), LOS (length of stay), IPPS (inpatient prospective payment system). Capital payments are determined by a similar system.
* Transfer policy for cases discharged to post-acute care settings applies for cases in 275 selected MS–DRGs.
** Additional payment made for certain rural hospitals.

CMS annually reviews the MS–DRG definitions to ensure that each group continues to include cases with clinically similar conditions requiring comparable amounts of inpatient resources. When the review shows that subsets of clinically similar cases within an MS–DRG consume significantly different amounts of resources, CMS often reassigns them to a different MS–DRG with comparable resource use or creates a new MS–DRG.

Facing fixed payment rates, providers have financial incentives to reduce their inpatient costs by moving some services to another setting. Medicare has adopted policies to counter these incentives. Thus, related outpatient department

services delivered in the three days before admission are included in the payment for the inpatient stay and may not be separately billed (referred to as the 72-hour rule). Similarly, payment is reduced when patients have a short length of stay and are transferred to another acute care hospital or, in many MS–DRGs, when patients are discharged to post-acute care settings.

Setting the payment rates

Medicare's payments are derived through a series of adjustments applied to separate operating and capital base payment rates. The two base rates are updated annually and are adjusted to reflect patient conditions, market conditions, and other factors recognized under Medicare's payment system. In 2014, the update is equal to the market basket (which measures the price increase of goods and services hospitals buy to produce patient care) less 0.3 percentage points and less the current 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity. The Secretary determines the update to the capital payment rate. Payments to hospitals that fail to provide data on specified quality indicators are reduced by 2 percent.

The base payment amounts Medicare sets per discharge base rates (known as standardized payment amounts) for the operating and capital costs that efficient facilities would be expected to incur in furnishing covered inpatient services. Operating payments cover labor and supply costs; capital payments cover costs for depreciation, interest, rent, and property-related insurance and taxes. For fiscal year 2014, the operating base rate is $5,370.[2] The capital rate is $429.

Certain costs are excluded from the acute inpatient PPS and paid separately, such as the direct costs of operating graduate medical education programs and organ acquisition costs.

The MS–DRG relative weights Medicare's operating and capital base rates are adjusted by an MS–DRG weight to reflect the patient's condition. Medicare assigns a weight to each MS–DRG reflecting the average relative costliness of cases in that group compared with that for the average Medicare case. CMS recalibrates the MS–DRG weights annually, without affecting overall payments, based on standardized costs for all PPS cases in each MS–DRG.

Adjustment for market conditions
Medicare's base operating and capital rates are adjusted by an area wage index to reflect the expected differences in local market prices for labor.[3] The wage index is intended to measure differences in hospital wage rates among labor markets; it compares the average hourly wage for hospital workers in each metropolitan statistical area or statewide rural area to the nationwide average.[4] The wage index is revised each year based on wage data reported by IPPS hospitals.

The wage index is applied to the labor-related portion of the base rate (usually called the "labor share"), which reflects an estimate of the portion of costs affected by local wage rates and fringe benefits. CMS's current operating labor share estimate of 69.6 percent is applied to hospitals with a wage index above 1.0. The Congress has legislated an operating labor share of 62 percent for hospitals located in areas with a wage index less than or equal to 1.0.

New technology payments Hospitals with cases treated using certain cost-increasing technologies receive add-on payments for new technologies. CMS evaluates applications by technology firms and others for add-on payments based on criteria of newness, substantial clinical improvement, and the costliness of the technology beyond the level of the current MS–DRG payment amount. New technology payments are additional to the MS–DRG payment and thus are not budget neutral.

Bad debts Medicare reimburses acute-care hospitals for 65 percent of bad debts resulting from beneficiaries' nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts.

Policy adjustments Certain hospitals receive additional operating and capital payments. Qualifying hospitals include those that operate medical resident training programs, treat a disproportionate share of low-income patients, or are located in a rural area and meet certain criteria. In addition, over 1,300 rural hospitals qualify as critical access hospitals and are paid on a cost basis (incurred costs plus 1 percent) instead of under the IPPS. The *Critical Access Hospitals Payment System* document in our "Payment Basics" series provides more information on this topic.

Medical education payments Teaching hospitals receive add-on payments to reflect the additional (indirect) costs of patient care associated with resident training. Nearly 95 percent of teaching facilities are located in urban areas, although they serve Medicare beneficiaries living in both urban and rural areas.

The size of the indirect medical education (IME) adjustment depends on the hospital's teaching intensity. For operating payments, teaching intensity is measured by a hospital's number of residents per bed.

For fiscal year 2014, the operating IME adjustment is roughly 5.5 percent for every 10 percent incremental increase in the resident-to-bed ratio.

Medicare pays separately for the direct costs of operating approved training programs for medical, dental, or podiatric residents. These graduate medical education (GME) payments are based on hospital-specific costs per resident in a base year. The per resident payment amounts are frozen for hospitals with amounts above 140 percent of the national average.

Disproportionate share payments Hospitals that treat a disproportionate share (DSH) of certain low-income patients receive additional operating and capital payments thought to offset the financial effects of these patients. Beginning in 2014, each hospitals' operating DSH payment adjustment will be derived from two separate equations. Under the first equation, hospitals will receive 25 percent of the DSH funds they would have received under prior law. Here, a hospital's low-income patient share is the sum of the proportion of its Medicare inpatient days provided to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. Any hospital with a low-income share exceeding 15 percent is eligible to receive operating DSH payments based on a complex formula. However, the add-on rate is capped at 12 percent of base inpatient payments for most rural hospitals and urban facilities with fewer than 100 beds.[5]

Second, pursuant to a provision in the Patient Protection and Affordable Care Act of 2010 (PPACA), hospitals will receive a share of a fixed pool of dollars defined as 75 percent of aggregated operating DSH payments under the prior law DSH formula multiplied by 1 minus the annual percentage decline in the national uninsured rate. This is referred to as the uncompensated care pool. In fiscal year 2014, as a proxy for hospital uncompensated care data, the uncompensated care pool will be allocated to hospitals based on their share of Medicaid and Medicare SSI days relative to all other hospitals receiving DSH payments. CMS projects a 5.6 percent decline in the national uninsurance rate between 2013 and 2014, and thus estimates that slightly more than $9 billion dollars will be allocated through this new method in 2014.

The capital DSH add-on payments are based completely on the prior law DSH formula and do not include a component based on uncompensated care. Capital DSH also only applies to urban hospitals with 100 or more beds and that serve low-income patients.

Special payments for rural hospitals Medicare makes additional payments to certain rural hospitals, although some urban facilities also may qualify. Hospitals located at least 35 miles from the nearest like hospital (excluding CAHs and Indian

Health Service hospitals) are eligible for the sole community hospital (SCH) program. These facilities receive the higher of payments under the IPPS or payments based on their costs in a base year updated to the current year and adjusted for changes in their case mix.

The Medicare-dependent hospital (MDH) program is for small rural hospitals in which Medicare patients comprise at least 60 percent of their admissions or patient days. These hospitals receive IPPS payments plus 75 percent of the difference between those payments and payments based on their updated base-year costs. This policy expired at the end of fiscal year 2013.

For fiscal years 2013 and 2014 hospitals receive an additional payment if they qualify as a low-volume facility. However, the low-volume policy changed significantly for fiscal year 2014. For fiscal year 2013, low-volume facilities were defined based on their Medicare discharges (fewer than 1,600 discharges) and were required to be located more than 15 miles from the nearest like hospital. These hospitals received as much as a 25 percent add-on to the prospective rate of each case, depending on their number of Medicare discharges. For fiscal year 2014, low-volume facilities are defined based on their total discharges (200 or fewer, including Medicare) and must be at least 25 miles from the nearest like hospital. These hospitals receive a 25 percent add-on to the prospective rate for each case.

Readmissions reduction policy As required by PPACA, the hospital readmission reduction program is being implemented beginning in fiscal year 2013. As a part of this program, hospitals that have excess Medicare readmissions for selected conditions will have their IPPS payments reduced. In fiscal year 2013 and fiscal year 2014 the readmissions policy will apply to just three conditions (acute myocardial infarction, heart failure, and pneumonia). Hospitals whose Medicare risk-adjusted readmission rates are greater than the national average rates will have their IPPS payments reduced. The payment penalty is capped at 1 percent of a hospital's base DRG payments in 2013 and 2 percent in 2014.

Value-based incentive payments As mandated by PPACA, the value-based incentive payment program will be implemented in fiscal year 2013. As a part of the program CMS will redistribute a pool of dollars equal to 1 percent of base inpatient DRG payments in 2013 and 1.25 percent in 2014 to hospitals based on their overall performance on a set of quality measures. The size of the value-based purchasing redistribution pool will increase by 0.25 percentage points each year, reaching a maximum of 2 percent of DRG payments for fiscal year 2017.

Outlier payments Some cases are extraordinarily costly, producing losses that may be too large for hospitals to offset. Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital MS–DRG payments.

Outlier cases are identified by comparing their costs to an MS–DRG-specific threshold that is the sum of the hospital's:

- MS–DRG payment for the case (both operating and capital),
- any IME, DSH, and new technology payments, and
- a fixed loss amount.

CMS sets a national fixed loss amount ($21,748 for fiscal year 2014), which is adjusted to reflect input price levels in the hospital's local market. Outlier payments are financed by prospective offsetting reductions in the operating base rate (5.1 percent) and the capital base rate (4.9 percent). CMS sets the national fixed loss amount at the level it estimates will result in outlier payments equaling the offset. Medicare pays 80 percent of hospitals' costs above their fixed loss thresholds.

Transfer policy Medicare reduces MS–DRG payments when patients:

- have a length of stay at least one day less than the geometric mean length of stay for the MS–DRG, [6]

- and are transferred to another hospital covered by the acute inpatient PPS, or in 275 MS–DRGs, are discharged to a post-acute care setting.

The post-acute settings covered by the transfer policy include long-term care hospitals; rehabilitation, psychiatric or skilled nursing facilities; and home health care if the patients receive clinically related care that begins within three days after the hospital stay.

Transferring facilities under this policy are paid a per diem rate rather than the full MS–DRG payment. Generally, hospitals receive twice the per diem rate for the first day and the per diem rate for each additional day up to the full MS–DRG rate.[7] ■

1 Medicare pays the approved amount minus any beneficiary liability, such as a deductible or copayment; the provider then collects the remaining amount from the beneficiary or a supplemental insurer.

2 Hospitals in Puerto Rico receive a 75/25 blend of the federal base payment amount and a Puerto Rico-specific rate.

3 A hospital may request geographic reclassification to an adjacent market area for its wage index and capital geographic adjustment factor. To qualify, a hospital must demonstrate proximity (location within 15 miles of the border of the adjacent area for urban hospitals and 35 miles for rural hospitals). It also must show that its hourly wages are above average for its market area (above 106 percent for rural hospitals and 108 percent for urban hospitals) and comparable to wages in the area to which it seeks reclassification (at least 86 percent of that area's average for rural hospitals and 88 percent for urban hospitals) in fiscal year 2011. Some hospitals also qualify for a higher wage index based on county commuting patterns of their employees.

4 In 2007, CMS implemented an occupational mix adjustment to the hospital wage index for nursing-related personnel. This adjustment is designed to ensure that wage index values do not reflect the effects of differences in mix of workers (a greater share of RNs and smaller share of nurse aides in some areas, for example).

5 The 12 percent cap does not apply to rural facilities with at least 500 beds, rural referral centers, or Medicare-dependent hospitals. An add-on of 35 percent of base inpatient payments is available for hospitals that receive at least 30 percent of their inpatient revenue (excluding Medicare and Medicaid) from state and local government subsidies. These are referred to as "Pickle" hospitals.

6 A geometric mean gives less weight to unusually long lengths of stay than an arithmetic mean, thus producing a lower estimate of the average length of stay and fewer cases affected by the transfer policy.

7 An exception exists for certain MS–DRGs with high first-day costs. These transfer cases are paid half the full MS–DRG payment plus one per diem payment and half the per diem rate for subsequent days up to the full MS–DRG rate.

INPATIENT PSYCHIATRIC FACILITY SERVICES PAYMENT SYSTEM

Medicare beneficiaries with serious mental illnesses or alcohol- and drug-related problems may be treated in specialty inpatient psychiatric facilities (IPFs), either freestanding hospitals or specialized hospital-based units.[1] The services furnished by IPFs are intended to meet the urgent needs of those experiencing an acute mental health crisis. Medicare payments to IPFs are estimated to be $4.3 billion in 2011. On average, Medicare beneficiaries account for about 25 percent of psychiatric facilities' revenue. In 2011, 302,000 beneficiaries had about 451,000 Medicare discharges from IPFs. About 1,517 facilities submitted Medicare cost reports in 2011.

To be admitted to an IPF, patients generally have to be considered a risk to themselves—either intentional or as the result of impaired self-care—or to others. As is the case for stays in short-term acute care hospitals, beneficiaries treated in IPFs are responsible for a deductible—$1,184 in 2013—for the first admission during a spell of illness, and for a copayment—$296 per day—for the 61st through 90th days. Beneficiaries treated for psychiatric conditions in IPFs are covered for 90 days of care per spell of illness, with a 60-day lifetime reserve.[2] Over their lifetimes beneficiaries are limited to 190 days of treatment in freestanding psychiatric hospitals.[3]

Defining the care Medicare buys

Under the prospective payment system (PPS) for IPF care, Medicare pays for the per diem routine, ancillary, and capital costs associated with furnishing covered inpatient psychiatric services. A base per diem payment is adjusted to account for differences in the cost of care related to specified patient and facility characteristics. The PPS was implemented in January 2005. Prior to that time, Medicare paid IPFs (under the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA) for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed the facility-specific limit that was adjusted annually.

Setting the payment rates

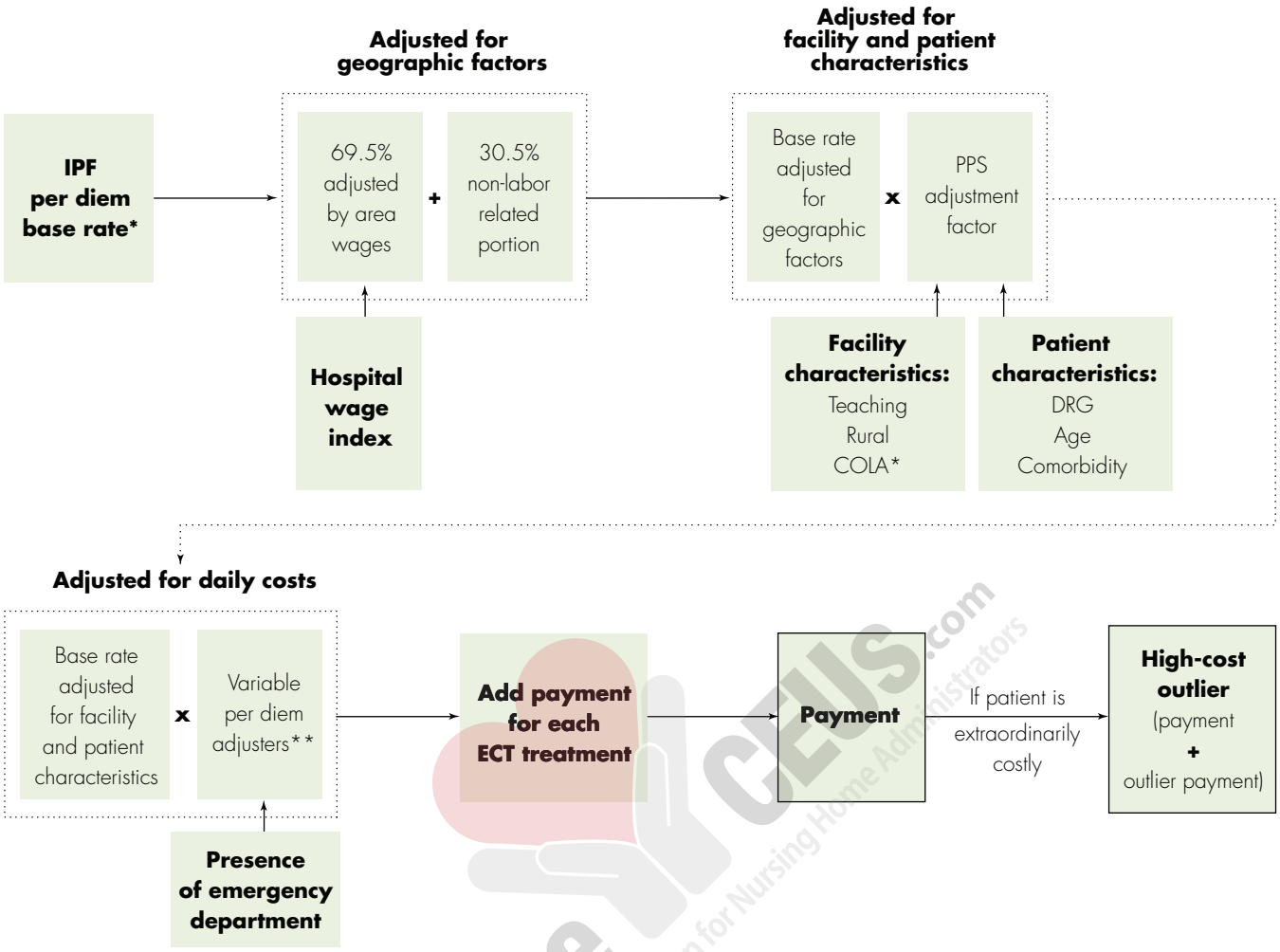
The base payment rate for each patient day in an IPF is based on the national average daily routine operating, ancillary, and capital costs in IPFs in 2002. For fiscal year (FY) 2014, the base payment rate is $713 per day. The base rate is adjusted to account for patient and facility characteristics that can be collected from administrative data and that are associated with significant cost differences (Figure 1). The patient characteristics include:

- **Age**—In general, payment increases with increasing patient age over 45.
- **Diagnosis**—Patients are assigned to one of 17 psychiatric Medicare severity diagnosis related groups (MS–DRGs), such as psychoses, depressive neuroses, and degenerative nervous system disorders. Medicare assigns a weight to each of the MS–DRGs reflecting the average costliness of cases in that group compared with that for the most frequently reported psychiatric diagnosis in FY 2002 (MS–DRG 885, psychosis).
- **Comorbidities**—This adjustment recognizes the increased costs associated with 17 specific patient conditions—such as renal failure, diabetes, and cardiac conditions—that are secondary to the patient's principal diagnosis and that require treatment during the stay.
- **Length of stay**—Per diem payments decrease as patient length of stay increases (Table 1).

Facility-based adjustments include:

- **Wage index adjustment**—The labor-related share (69.5 percent) of the base

Figure 1 Inpatient psychiatric facility services prospective payment system



Note: IPF (inpatient psychiatric facility), PPS (prospective payment system), COLA (cost of living adjustment), DRG (diagnosis related group), ECT (electro-convulsive therapy).
*A cost of living adjustment (COLA) to the non-labor related portion is made for facilities in Alaska and Hawaii.
**The variable per diem adjuster is higher for the 1st day when an emergency department is present. The adjuster declines from 1.31 with an emergency department and 1.19 without an emergency department to 0.92 over time. Table 1 shows the adjuster.

per diem payment is adjusted by an area wage index to reflect the expected differences in local market prices for labor.

- **Rural location adjustment**—IPFs in rural areas are paid 17 percent more than urban IPFs.
- **Teaching adjustment**—Teaching hospitals have an adjustment based on the ratio of interns and residents to average daily census.
- **Cost of living adjustment**—IPFs in Alaska and Hawaii are paid up to 25 percent more than IPFs located in other areas, reflecting their disproportionately higher costs.
- **Emergency department adjustment**—IPFs with qualifying emergency departments are paid about 10 percent more for their patients' first day of the stay.

IPFs also receive an additional payment for each electroconvulsive therapy (ECT) treatment furnished to a patient. In FY 2013, the ECT payment is $307.

Patients who are readmitted to the IPF within three days of discharge are considered to have an interrupted stay. In such cases, Medicare treats the readmission as a continuation of

the original stay, with lengths of stay adjustments applied accordingly.

Outlier payments—The IPF PPS has an outlier policy for cases that have extraordinarily high costs, drawn from an outlier pool of 2 percent of total payments. Medicare makes outlier payments when an IPF's estimated total costs for a case exceed a threshold ($10,245 in FY 2014, adjusted for the facility characteristics outlined above) plus the total payment amount for the case. Medicare will cover 80 percent of the costs above this amount for days 1 through 9, and 60 percent of the costs above this amount for the remaining days. The different risk-sharing rates are intended to counteract the financial incentives to keep outlier cases longer than may be necessary.

Payment updates

There is no mechanism in law for updating payments to IPFs. CMS has stated that it intends to update the IPF payment rates based on the most recent estimate of the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket index (which measures the price increases of goods and services inpatient rehabilitation facilities, inpatient psychiatric facilities, and LTCHs buy to produce patient care). The Patient Protection and Affordable Care Act of 2010 requires that any annual update to the IPF payment rates in fiscal years 2012 through 2019 be reduced by an adjustment for productivity. ■

1 Beneficiaries are also treated for psychiatric or alcohol and drug-related conditions in regular beds in acute care hospitals; in these instances providers are paid under the acute care inpatient prospective payment system (PPS).

2 The number of inpatient benefit days in the first benefit period is reduced for individuals who are in a Medicare participating IPF on their first day of entitlement to Medicare Part A. Beneficiaries are liable for a higher copayment for each lifetime reserve day—$592 per day in 2013.

3 This restriction, which was intended to limit the federal government's role in paying for long-term custodial care of beneficiaries with mental illnesses, applies only to services furnished in freestanding IPFs. The limitation does not apply to inpatient psychiatric services furnished in a specialized psychiatric unit of an acute care hospital, nor does it apply to psychiatric stays paid for under the acute care hospital prospective payment system.

Table 1 The adjusted rate for IPFs is higher for earlier days of a patient's stay

Day of patient's stay	Per diem adjustment
1 Facility:	
with a full-service emergency department	1.31
without a full-service emergency department	1.19
2	1.12
3	1.08
4	1.05
5	1.04
6	1.02
7	1.01
8	1.01
9	1.00
10	1.00
11	0.99
12	0.99
13	0.99
14	0.99
15	0.98
16	0.97
17	0.97
18	0.96
19	0.95
20	0.95
21	0.95
22 or more	0.92

Note: IPF (inpatient psychiatric facility). The per diem adjustment is applied to the base rate that is already adjusted for geographic, facility, and patient characteristics.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System—Update for Fiscal Year Beginning October 1, 2013 (FY 2014). *Federal Register* 78, no. 148 (August 1): 46743.

INPATIENT REHABILITATION FACILITIES PAYMENT SYSTEM

After an illness, injury, or surgical care, some patients need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. Relatively few beneficiaries use intensive rehabilitation therapy because they generally must be able to tolerate and benefit from three hours of therapy per day to be eligible for treatment in an inpatient rehabilitation setting. Inpatient rehabilitation facilities (IRFs) may be freestanding hospitals or specialized, hospital-based units. Hospital-based units represent approximately 80 percent of facilities, but only 55 percent of Medicare IRF discharges. Medicare payments to IRFs totaled an estimated $6.46 billion in 2011. Medicare accounts for about 60 percent of IRF cases. In 2011, there were about 370,000 fee-for-service Medicare cases, and in 2012 about 1,170 facilities were Medicare certified.

Beneficiaries transferred to an IRF from an acute care hospital pay no additional deductible. However, beneficiaries admitted from the community are responsible for a deductible—$1,184 in 2013—as the first admission during a spell of illness. Beneficiaries are responsible for a copayment—$296 per day—for the 61st through 90th days. Coverage of IRF stays is subject to Medicare's limits on inpatient hospital care; thus beneficiaries' IRF stays are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.[1]

In January 2002, CMS implemented the inpatient rehabilitation facility prospective payment system (PPS). Under the IRF PPS, IRFs are paid predetermined per discharge rates based primarily on the patient's condition (diagnoses, functional and cognitive statuses, and age) and market area wages. Before 2002, IRFs were paid for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed the facility-specific limit that was adjusted annually.

Under the PPS, discharges are assigned to case-mix categories organized by clinical problems and expected resource needs. Each case-mix category has a national relative weight reflecting the expected relative costliness of treatment for patients in that category compared with that for the average Medicare inpatient rehabilitation patient.

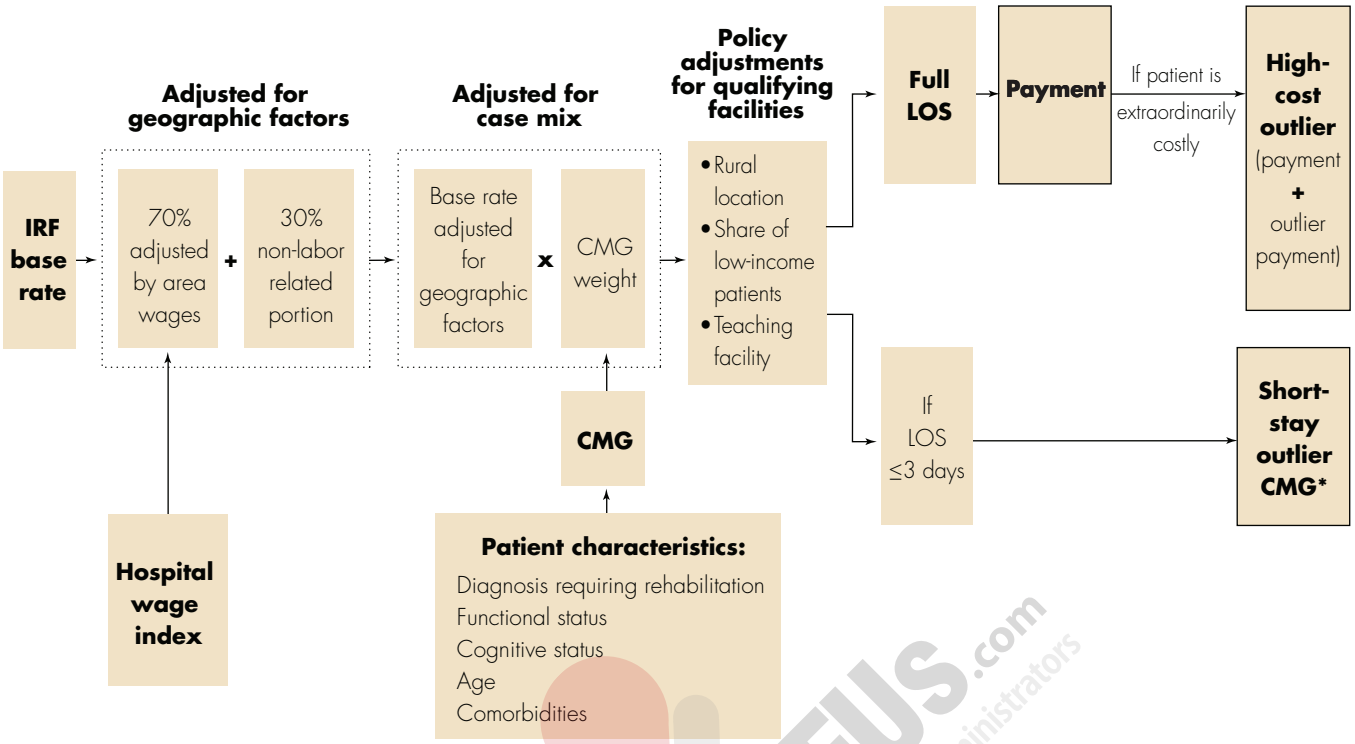
Defining the inpatient rehabilitation products Medicare buys

Under the inpatient rehabilitation facility PPS, Medicare patients are assigned to one of 92 intensive rehabilitation categories called case-mix groups (CMGs). In 87 of these treatment categories, patients are assigned based on the primary reason for intensive rehabilitation care (for example, a stroke or burns); their age and levels of functional and cognitive impairments; and the types of comorbidities (coexisting conditions) present during the stay. Within each of these CMGs, patients are further categorized into one of four tiers based on any particular comorbidities they may have that have been found to increase the cost of care relative to the costs of caring for an average beneficiary in that CMG. Each tier has a specific payment that reflects the costliness of patients in that tier relative to others in the CMG. The other five categories are for patients discharged before the fourth day—called short-stay outliers—and for those few who die in a facility. Further, IRFs may receive lower payments for other patients who are discharged to another facility and the length of stay is less than that typically provided to patients with the same condition.

Setting the payment rates

The PPS payment rates cover all operating and capital costs that IRFs would be expected to incur in furnishing intensive rehabilitation services. The base rate—

Figure 1 Inpatient rehabilitation facility prospective payment system



Note: IRF (inpatient rehabilitation facility), CMG (case-mix group), LOS (length of stay).
*IRFs with a wage index of 1.0 are paid $2,283 for short-stay outliers.

$14,846 for fiscal year 2014—is adjusted for area wages by multiplying the labor-related portion of the base payment amount—70 percent—by a version of the hospital wage index and the result is added to the nonlabor portion (Figure 1). The sum is then case-mix adjusted by multiplying the local base rate by the relative weight for the CMG to create the PPS payment rate for each patient.

Payment rates are increased for IRFs that are located in rural markets, treat low-income patients, or are teaching institutions. Rural facilities' payment rates are increased by 14.9 percent because they tend to have fewer cases, longer lengths of stay, and higher average costs per case. An IRF's payments are adjusted for the share of low-income patients it treats—the adjustment is based on the sum of two proportions: the proportion of total Medicare days furnished to beneficiaries eligible for Supplemental Security Income benefits and the proportion of total patient days furnished to Medicaid patients not covered by Medicare. Unlike acute care hospitals, IRFs do not have to reach a threshold of the share of low-income patients before payments are adjusted. Payments for IRFs that are teaching institutions are adjusted according to the ratio of their residents to their average daily census.

Both the base rate and relative weights are updated annually. The base rate is updated using the market basket index (including capital) for facilities originally excluded from the acute care hospital PPS (IRFs, long-term care hospitals, inpatient psychiatric facilities, cancer, and children's hospitals). The Patient Protection and Affordable Care Act of 2010 (PPACA) provided a reduction to the market basket increase and an adjustment for productivity for fiscal year 2014, resulting in an adjusted fiscal year 2014 payment

increase factor of 1.8 percent. The relative weights are updated based on changes in national average charges per discharge for each CMG.

IRFs have two outlier policies. One is for patients with short stays (less than or equal to three days) for which IRFs are paid lower rates—in fiscal year 2014, $2,283 for an IRF with a wage index of 1.0. The other is for high-cost outliers when costs exceed a fixed-loss threshold. This outlier threshold is the regular payment rate plus a national fixed-loss amount ($9,272 for fiscal year 2014), adjusted by the wage index and the other facility-level payment adjustments. For high-cost outliers, IRFs receive their regular payment rates plus 80 percent of their costs above the fixed-loss threshold. Total outlier payments are estimated to be 3 percent of spending for IRFs.

The 60 percent rule

The 60 percent rule, formerly known as the 75 percent rule, is a criterion used to define inpatient rehabilitation facilities in order for them to receive payment as an IRF. The rule requires that at least 60 percent of cases an IRF admits have one or more selected conditions that typically require intensive rehabilitation therapy. The 13 qualifying medical conditions used to classify a facility as an IRF are:

- stroke
- spinal cord injury
- congenital deformity
- amputation
- major multiple trauma
- hip fracture
- brain injury
- neurological disorders (e.g., multiple sclerosis, Parkinson's disease)
- burns
- three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed, and
- hip or knee replacement when bilateral, when body mass index ≥50, or age 85 or older.

The 60 percent rule, established in 2007 by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), replaces the 75 percent rule that preceded it. CMS had, in 2002, suspended enforcement of the 75 percent rule due to inconsistent implementation by the claims processing contractors. CMS resumed enforcement of the 75 percent rule in 2004 and was in the midst of gradually phasing in the threshold from 50 percent to 75 percent over a five-year period when the MMSEA permanently rolled back the threshold to 60 percent.

The MMSEA also made permanent a policy allowing secondary medical conditions to meet the 13 medical conditions that qualify toward the threshold. The secondary condition, even in the absence of the admitting condition, must cause a significant enough decline in the patient's functioning that the individual would need intensive rehabilitation services best provided in an IRF. ■

1 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$592 per day in 2013.

LONG-TERM CARE HOSPITALS PAYMENT SYSTEM

Patients with chronic critical illness—those who exhibit metabolic, endocrine, physiologic, and immunologic abnormalities that result in profound debilitation and often ongoing respiratory failure—frequently need hospital-level care for relatively extended periods. Nationwide, most chronically critically ill (CCI) patients are treated in acute care hospitals, but some are admitted to long-term care hospitals (LTCHs). These facilities can be freestanding or co-located with other hospitals as hospitals-within-hospitals (HWHs) or satellites. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for its Medicare patients. Medicare payments to LTCHs were about $5.4 billion in 2011; Medicare beneficiaries accounted for about two-thirds of these hospitals' revenues. In 2011, about 123,000 Medicare beneficiaries had almost 140,000 discharges from LTCHs, and 424 facilities were Medicare certified.[1] LTCHs are not distributed evenly through the nation.

Beneficiaries transferred to an LTCH from an acute care hospital pay no additional deductible. However, beneficiaries admitted from the community are responsible for a deductible—$1,184 in 2013—as the first admission during a spell of illness. An additional copayment is required if the beneficiary's hospital stay (whether in an acute care hospital, an LTCH, or combined) extends beyond 60 days during a spell of illness. In 2013, the copayment is $296 per day for the 61st through 90th days. Beneficiaries treated in LTCHs are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.[2]

Since October 2002, Medicare has paid LTCHs predetermined per discharge rates based primarily on the patient's diagnosis and market area wages. Before then, LTCHs were paid for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed a facility-specific limit that was adjusted annually.

Under the PPS, discharges are assigned to case-mix groups containing patients with similar clinical problems that are expected to require similar amounts of resources. Each case-mix group has a national relative weight reflecting the expected costliness of treatment for a patient in that category compared with that for the average LTCH patient.

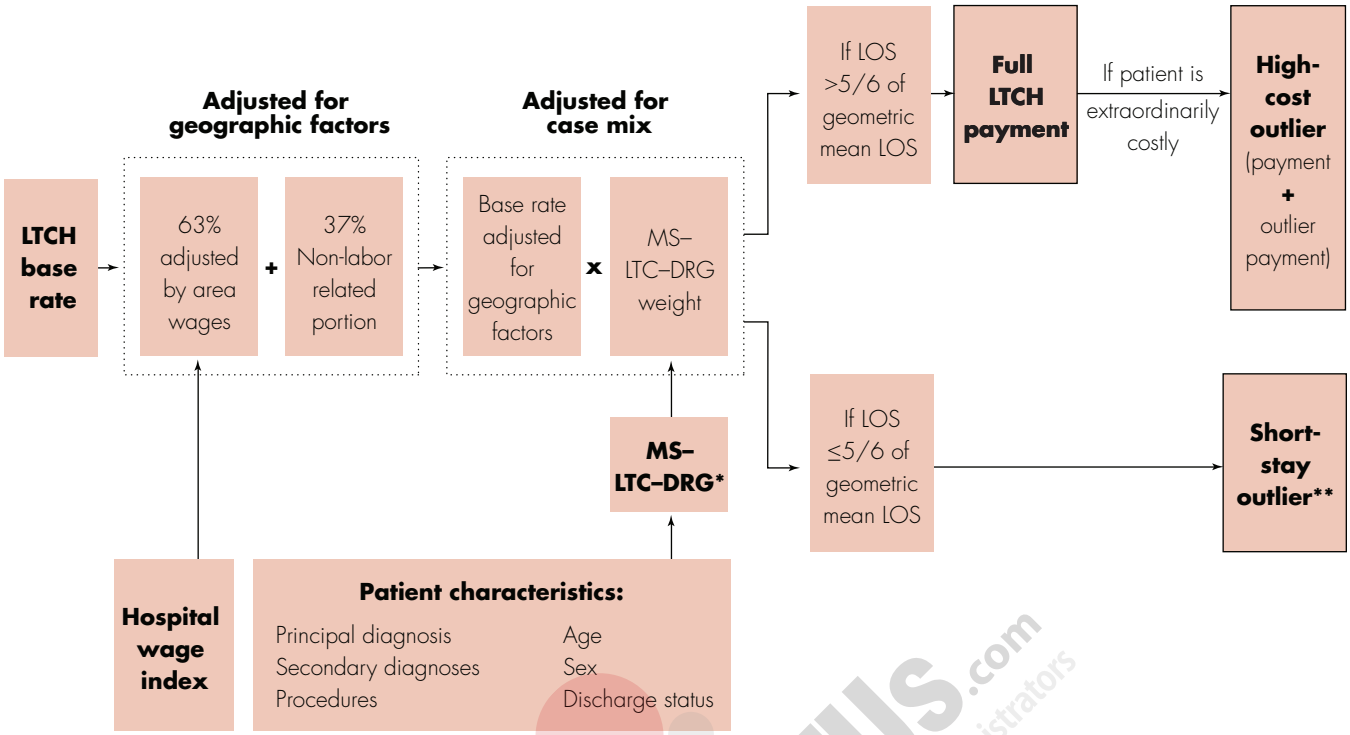
Defining the long-term care hospital product Medicare buys

Under the LTCH prospective payment system (PPS), Medicare pays for the operating and capital costs associated with hospital inpatient stays in LTCHs. Medicare sets per discharge payment rates for different case-mix groups called Medicare severity long-term care diagnosis related groups (MS–LTC–DRGs) based on the expected relative costliness of treatment for patients in the group. Patients are assigned to these groups based on their principal diagnosis, secondary diagnoses, procedures performed, age, sex, and discharge status. The MS–LTC–DRGs are the same groups used in the acute inpatient PPS but have relative weights specific to LTCH patients, reflecting the average relative costliness of cases in the group compared with that for the average LTCH case.[3]

Setting the payment rates

The PPS payment rates cover all operating and capital costs that LTCHs would be expected to incur in furnishing covered services. The initial payment level (base rate) for a typical discharge in fiscal year 2014 is $40,607.

Figure 1 Long-term care hospital prospective payment system



Note: LTCH (long-term care hospital), MS–LTC–DRG (Medicare severity long-term care diagnosis related group), LOS (length of stay).
* MS–LTC–DRGs comprise base DRGs subdivided into one, two, or three severity levels.
** Payments generally are reduced for short-stay patients.

The base rate is adjusted to account for differences in market area wages (Figure 1). The labor-related portion of the base payment amount—63 percent—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion.[4] For LTCHs in Alaska and Hawaii, the nonlabor portion is adjusted by a cost of living adjustment (COLA) and added to the labor-related portion.[5] The adjusted rate for each market is multiplied by the relative weights for all MS–LTC–DRGs to create local PPS payment rates.

Short-stay outliers—LTCHs are paid adjusted PPS rates for patients who have short stays. Short-stay outliers (SSOs) are cases with a length of stay up to and including five-sixths of the geometric average length of stay for the MS–LTC–DRG. For SSOs, LTCHs are paid the least of:

- 100 percent of the cost of the case,
- 120 percent of the MS–LTC–DRG specific per diem amount multiplied by the length of stay for that case,
- the full MS–LTC–DRG payment, or
- an amount that is a blend of the inpatient PPS amount for the MS–DRG and the 120 percent of the LTCH per diem payment amount. As the length of stay for the SSO increases, the portion of payment attributable to the LTCH per diem increases.

Beginning December 29, 2012, Medicare applies a different standard for the shortest SSO cases. These cases are those in which length of stay is less than or equal to the average length of stay for the same MS–DRG at acute care hospitals paid under the inpatient PPS (IPPS) plus one standard deviation. For very short-stay cases that meet this "IPPS comparable threshold," LTCHs are paid the least of:

- 100 percent of the cost of the case,
- 120 percent of the LTC–DRG specific per

diem amount multipled by the length of stay for that case,
- the full LTC–DRG payment, or
- the IPPS per diem amount multiplied by the length of stay for the case, not to exceed the full IPPS payment amount.[6]

High-cost outliers—LTCHs are paid outlier payments for patients who are extraordinarily costly. High-cost outlier cases are identified by comparing their costs to a threshold that is the MS–LTC–DRG payment for the case plus a fixed loss amount. In FY 2014 the fixed loss amount is $13,314. Medicare pays 80 percent of the LTCHs' costs above the threshold. High-cost outlier payments are funded by reducing the base payment amount for all LTCHs by 8 percent.

Interrupted stays—LTCHs receive one payment for "interrupted-stay" patients. An interrupted stay is when an LTCH patient is discharged to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF), stays for a specified period, then goes back to the same LTCH. The specified period of time is 9 days for an acute care hospital, 27 days for an IRF, and 45 days for a SNF. Any LTCH discharge readmitted within three days is also considered an interrupted stay.

LTCHs that are co-located with other Medicare providers are subject to the interrupted-stay policy unless their readmissions exceed 5 percent of the LTCH's total discharges. If this limit is exceeded, the LTCH receives only one payment for each interrupted-stay patient regardless of the amount of time spent at the intervening facility. (A separate 5 percent threshold applies to cases transferred to co-located SNFs, IRFs, and psychiatric facilities.)

The 25 percent rule

The 25 percent rule reduces payments for LTCHs that exceed established percentage thresholds for patients admitted from certain referring hospitals during a cost-reporting period. The rule is intended to help ensure that LTCHs do not function as units of acute care hospitals and that decisions about admission, treatment, and discharge in both acute care hospitals and LTCHs are made for clinical rather than financial reasons.

When first implemented, the 25 percent rule applied only to LTCH hospitals within hospitals (HWHs) and satellites, limiting the proportion of Medicare patients who could be admitted from a HWH's or satellite's host hospital during a cost reporting period. The policy was phased in over three years, with the threshold for most HWHs and satellites set at 75 percent for fiscal year 2006, 50 percent for fiscal year 2007, and 25 percent for fiscal year 2008. (Less stringent thresholds are applied to HWHs and satellites in rural areas or in urban areas where they are the sole LTCH or where there is a dominant acute care hospital.) After the threshold is reached, the LTCH is paid the lesser of the LTCH PPS rate or an amount equivalent to the acute care hospital PPS rate for patients discharged from the host acute care hospital.[7] Patients from the host hospital who are outliers under the acute hospital PPS before their transfer to the HWH do not count toward the threshold and continue to be paid at the LTCH PPS rate even if the threshold has been reached.

Beginning in July 2007, CMS expanded the 25 percent rule to apply to all freestanding LTCHs, limiting the proportion of patients who can be admitted to an LTCH from any one acute care hospital during a cost reporting period. The extended policy was to be phased in over three years, with the applicable threshold for non-HWHs and nonsatellites set at 75 percent for rate year 2008.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) substantially changed the 25 percent rule by rolling back the phased-in implementation of the 25 percent rule for HWHs and satellites and preventing application of the rule to freestanding LTCHs for three years. The Patient Protection and Affordable Care Act

(PPACA) and the Health Care Education Reconciliation Act of 2010 extended the roll-back for an additional two years, until FY 2013. CMS opted to continue that extension until FY 2014. The 25 percent rule will be fully implemented for all LTCHs for cost reporting periods beginning on or after October 1, 2013.

Payment updates

There is no mechanism in law for updating payments to LTCHs. CMS has stated that it intends to update LTCH PPS payment rates based on the most recent estimate of an LTCH-specific market basket index (which measures the price increases of goods and services LTCHs buy to produce patient care). PPACA requires that any annual update to the LTCH payment rates in fiscal years 2012 through 2019 be reduced by an adjustment for productivity. ■

1 Medicare beneficiaries enrolled in Medicare Advantage plans are not included in these aggregate totals.

2 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$592 per day in 2013.

3 MS–LTC–DRGs with fewer than 25 cases are grouped into 5 categories based on their average charges; relative weights for these 5 case-mix groups are determined based on the average charges for the MS–LTC–DRGs in each of these groups.

4 The wage index used to adjust LTCH payments is calculated from wage data reported by acute care hospitals without the effects of geographic reclassification.

5 The COLA is intended to reflect the higher costs of supplies and other nonlabor resources in Alaska and Hawaii. It increases the nonlabor portion of the payment by as much as 25 percent.

6 The policy for very short-stay cases was first implemented in July 2007. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), as amended by the Patient Protection and Affordable Care Act (PPACA) provided for a 5-year moratorium on the application of the policy.

7 During the year, the HWH will be paid the LTCH rate. During retrospective settlement at the end of an HWH's cost report year, if the HWH is determined to be overpaid, CMS will collect the overpayments from future payments.

MEDICARE ADVANTAGE PROGRAM PAYMENT SYSTEM

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive their Medicare benefits from private plans rather than from the traditional fee-for-service (FFS) program. Under some MA plans, beneficiaries may receive additional benefits beyond those offered under traditional Medicare and may pay additional premiums for them. Medicare pays plans a capitated rate for the 28 percent of beneficiaries enrolled in MA plans in 2013. These payments amounted to $136 billion in 2012.

Available MA plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and special needs plans (SNPs). For payment purposes, there are two different categories of MA plans: local plans and regional plans. Local plans may be any of the available plan types and may serve one or more counties. Medicare pays them based on their enrollees' counties of residence. Regional plans, however, must be PPOs and must serve all of one of the 26 regions established by the Centers for Medicare & Medicaid Services (CMS). Each region comprises one or more entire states.

Defining the Medicare Advantage products Medicare buys

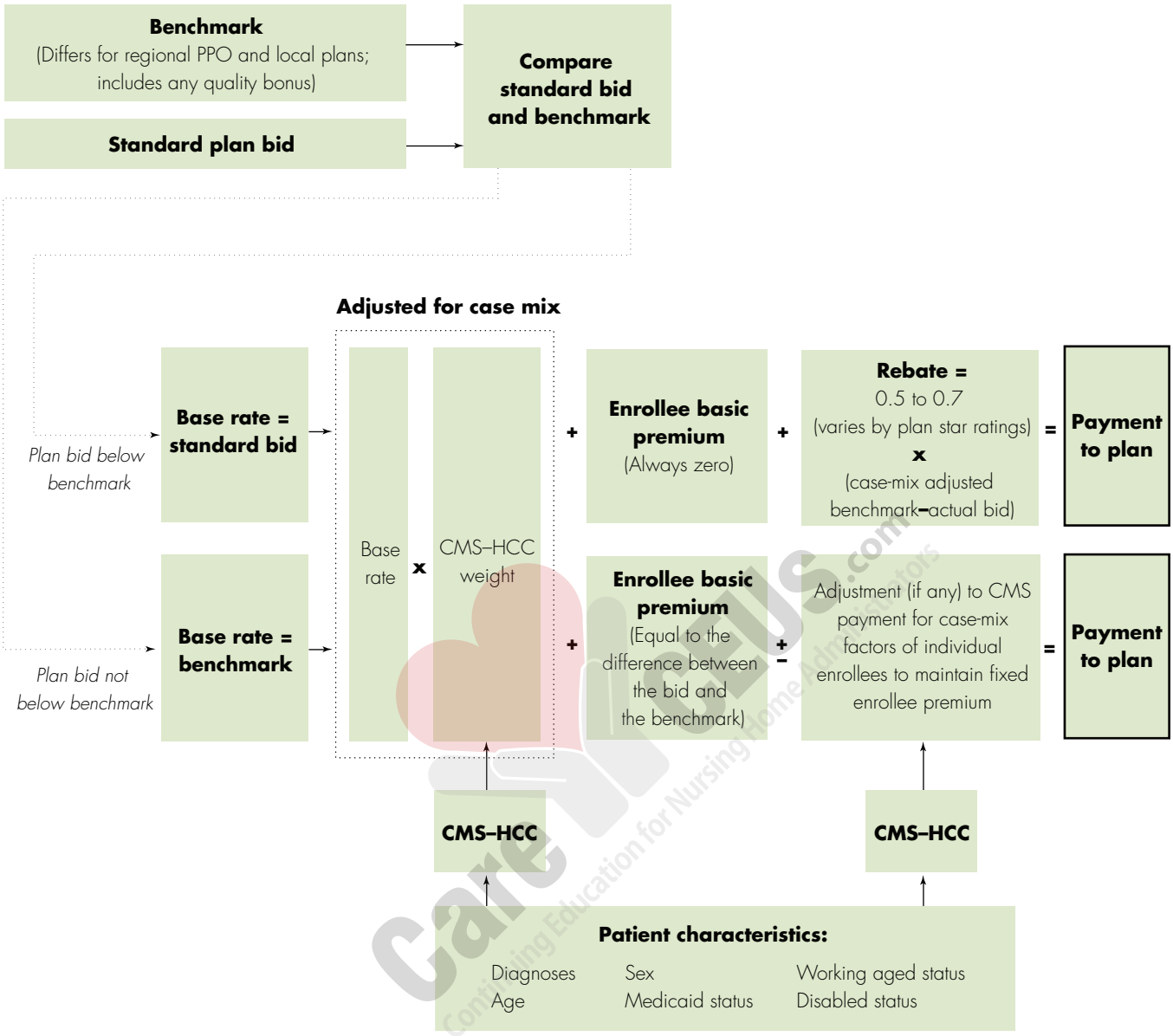
Under the MA program, Medicare buys insurance coverage for its beneficiaries from private plans with payments made monthly. The coverage must include all Medicare Part A and Part B benefits except hospice. All plans, except PFFS plans, must also offer an option that includes the Part D drug benefit. Plans may limit enrollees' choices of providers more narrowly than under the traditional fee-for-service (FFS) program. Plans may supplement Medicare benefits by reducing cost-sharing requirements or providing coverage of non-Medicare benefits. Plans may charge a premium for these benefits.

Determining Medicare payment for local MA plans

Plan bids partially determine the Medicare payments they receive (Figure 1). Plans bid to offer Parts A and B (Part D coverage is handled separately) coverage to Medicare beneficiaries. The bid here is presented as the bid to cover an average, or standard, beneficiary. The bid will include plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and benchmark.

The benchmark is a bidding target. The local MA benchmarks are determined under statutory formulas whereby county-level rates vary depending on several factors. Beginning in 2012, pursuant to the Patient Protection and Affordable Care Act of 2010 (PPACA), the factors determining the benchmark levels include the relationship between a county's per capita Medicare FFS program expenditures and the national average level of FFS program expenditures, as well as plan quality indicators. The years 2012 through 2016 are transition years in which benchmarks will be a blend of the rates determined under pre-PPACA provisions and benchmarks determined under the new payment system that will be in full effect in all counties as of 2017.[1] The benchmark will also vary from plan to plan depending on a plan's ranking in the CMS star system that measures the quality of care that plans provide. Plans with higher quality rankings will have bonus amounts added to benchmark levels. In certain counties—urban areas with low FFS expenditure levels and historically high Medicare managed care enrollment—plans

Figure 1 Medicare Advantage payment system for nondrug benefits, 2014



Note: PPO (preferred provider organization), CMS–HCC (CMS–hierarchical condition category). If the plan bid equals the benchmark, there is no enrollee basic premium. Medicare payments also reflect an intra-service area adjustment based on the county of residence of the enrollee.

with high star rankings can have their benchmark bonuses doubled.

During the transition period there will be a blended benchmark with two components, a portion of the benchmark determined under pre-PPACA rules and a portion determined under the new system. The share for each component will depend on how great the difference would have been between benchmarks computed under each of the two systems when applied as of 2010. For 2014 benchmarks, the new system will be fully in effect for counties with the smallest difference between the two components of the blended benchmark levels (a difference

of under $30 between the pre-PPACA computation and the computation under the new system when applied as of 2010). For counties in which the difference is $30 or more and less than $50, the transition will be four years, with the new system fully implemented in 2015, and the 2014 benchmark blend set at 1/4 of the pre-PPACA computed amount and 3/4 under the new system. For six-year transition counties—where the difference is greater than or equal to $50—the 2014 blend is 1/2 (3/6) based on the pre-PPACA computed amount and 1/2 under the new system. There is also a statutory cap on the blended benchmark amount whereby the blended amount for transition years may not exceed the level of the benchmark amount determined under pre-PPACA rules. For the period 2012–2014, CMS has implemented a demonstration applicable to all plans for which bonus payments based on star ratings would be above those specified in the statute, and the cap on blended benchmarks would not apply to these plans. Regional benchmarks are based on the local benchmarks and are discussed in detail later in this document.

If a plan's standard bid is above the benchmark, then the plan receives a base rate equal to the benchmark and the enrollees have to pay a basic premium that equals the difference between the bid and the benchmark. The base rate for a plan bidding at the benchmark is the benchmark. If a plan bid falls below the benchmark, the plan receives a base rate equal to its standard bid.

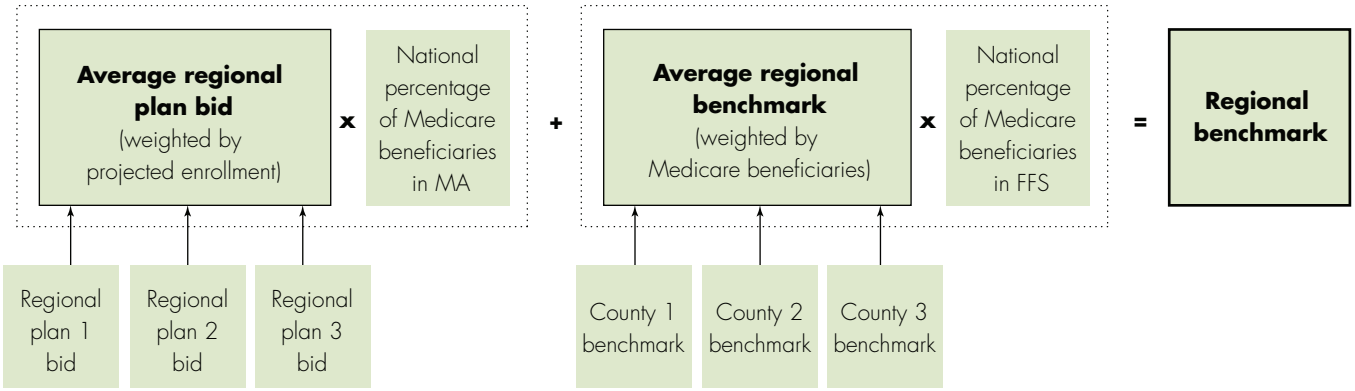
Medicare payments are also based on enrolled beneficiaries' demographics and health risk characteristics. Medicare uses beneficiaries' characteristics, such as age and prior health conditions, and a risk-adjustment model—the CMS–hierarchical condition category (CMS–HCC)—to develop a measure of their expected relative risk for covered Medicare spending. The payment for an enrollee is the base rate for the enrollee's county of residence, multiplied by the enrollee's risk measure, also referred to as the CMS–HCC weight.

Plans that bid below the benchmark also receive payment from Medicare in the form of a "rebate." The law defines the rebate as a fixed percentage of the difference between the plan's actual bid (not standardized) and its case-mix-adjusted benchmark. As of 2014 and thereafter, the fixed percentages will be 50, 65 and 70 percent, depending on a plan's star rating. Once the rebate dollars are determined, the plan must then return the rebate to its enrollees in the form of supplemental benefits or lower premiums. The plan can apply any premium savings to the Part B premium (in which case the government retains the amount for that use), to the Part D premium, or to the premium for the total package that may include supplemental benefits.

For plans bidding at or above the benchmark, there are no rebates. If a plan bids above the benchmark, the enrollee pays a premium equal to the difference between the standardized benchmark and the standardized bid. Medicare's payment to the plan is the case-mix-adjusted benchmark. For plans with a case mix that is different from the average case mix (either less or more healthy than the case mix represented by the standardized bid), the Medicare payment is adjusted upwards or downwards to reflect the enrollee premium payments, which are fixed at the standardized amount for each enrollee.

The above system relates to Medicare payments for Part A and Part B services. When a plan offers Part D prescription drug benefits as part of its package, it submits a separate bid for the Part D portion. Payment for the Part D prescription drug portion of the plan benefits is calculated separately, the same way as if the plan were offering a stand-alone prescription drug package. The *Part D Payment System* document in our "Payment Basics" series provides more information on this topic. The only difference from stand-alone prescription drug plans is that the MA plan may choose to apply some of its rebate payments to lower the Part D premium that enrollees would otherwise be required to pay.

Figure 2 Setting a benchmark for regional PPOs



Note: PPO (preferred provider organization), MA (Medicare Advantage), FFS (fee-for-service).

Determining Medicare payment for regional MA plans

Aside from a few special payment incentives, payment for regional MA plans is determined like payment for local plans, except that the benchmarks are calculated differently (Figure 2).

CMS determines the benchmarks for the MA regional plans by using a more complicated formula that incorporates the plan bids. A region's benchmark is a weighted average of the average county rate and the average plan bid. As directed by law, CMS computes the average county rate as the individual county rates weighted by the number of Medicare beneficiaries who live in each county. The average plan bid is each plan's bid weighted by each plan's projected number of enrollees. CMS then combines the average county rate and the average bid into an overall average. In calculating the overall average, the average bid is weighted by the number of enrollees in all private plans across the country, and the average county rate is weighted by the number of all Medicare beneficiaries who remain in FFS Medicare. ■

1 In 2017, after the transition is completed for all areas, a county benchmark will be at one of four quartile levels. The benchmark will be 95, 100, 107.5 or 115 percent of the FFS projected rate for that county for the year, with the quartile assignment depending on the relative FFS expenditure levels among counties during the preceding year. If a county changes its quartile position from one year to the next, the percentage of FFS amount determining the county benchmark will be the average of the two percentages in each of the different years.

OUTPATIENT DIALYSIS SERVICES PAYMENT SYSTEM

Individuals with end-stage renal disease (ESRD)—irreversible loss of kidney function—require either dialysis or kidney transplantation to survive. In 1972, the Social Security Act extended all Medicare Part A and Part B benefits to individuals with ESRD who are entitled to receive Social Security benefits. This entitlement is nearly universal, covering more than 90 percent of all people with ESRD in the United States.

Because of the scarcity of kidneys available for transplantation, most patients with ESRD (70 percent) receive maintenance dialysis. Medicare spending for outpatient dialysis and injectable drugs administered during dialysis was about $10.1 billion in 2011 and is a predominant share of revenues for dialysis facilities.

Since 1983, Medicare has paid dialysis facilities a predetermined rate intended to cover a specific bundle of services provided to patients in a given dialysis treatment. To improve provider efficiency, Medicare began in 2011 to phase in a modernized prospective payment system (PPS) for outpatient dialysis services. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) broadened the payment bundle to include dialysis drugs, laboratory tests, and other ESRD-related items and services that were previously separately billable. MIPPA also required CMS to implement a pay-for-performance program beginning in 2012. Most dialysis facilities elected to be paid under the modernized PPS instead of the four-year transition. Table 1 summarizes key differences between the modernized and the prior payment systems.

Defining the care that Medicare buys

Medicare covers two methods of dialysis—hemodialysis and peritoneal dialysis. In hemodialysis, a patient's blood is cycled through a dialysis machine, which filters out body waste. More than 90 percent of all dialysis patients undergo hemodialysis three times per week in dialysis facilities. Peritoneal dialysis uses the lining of the peritoneal cavity to filter excess waste products, which are then drained from the abdomen. Patients undergo peritoneal dialysis five to seven times per week in their homes.

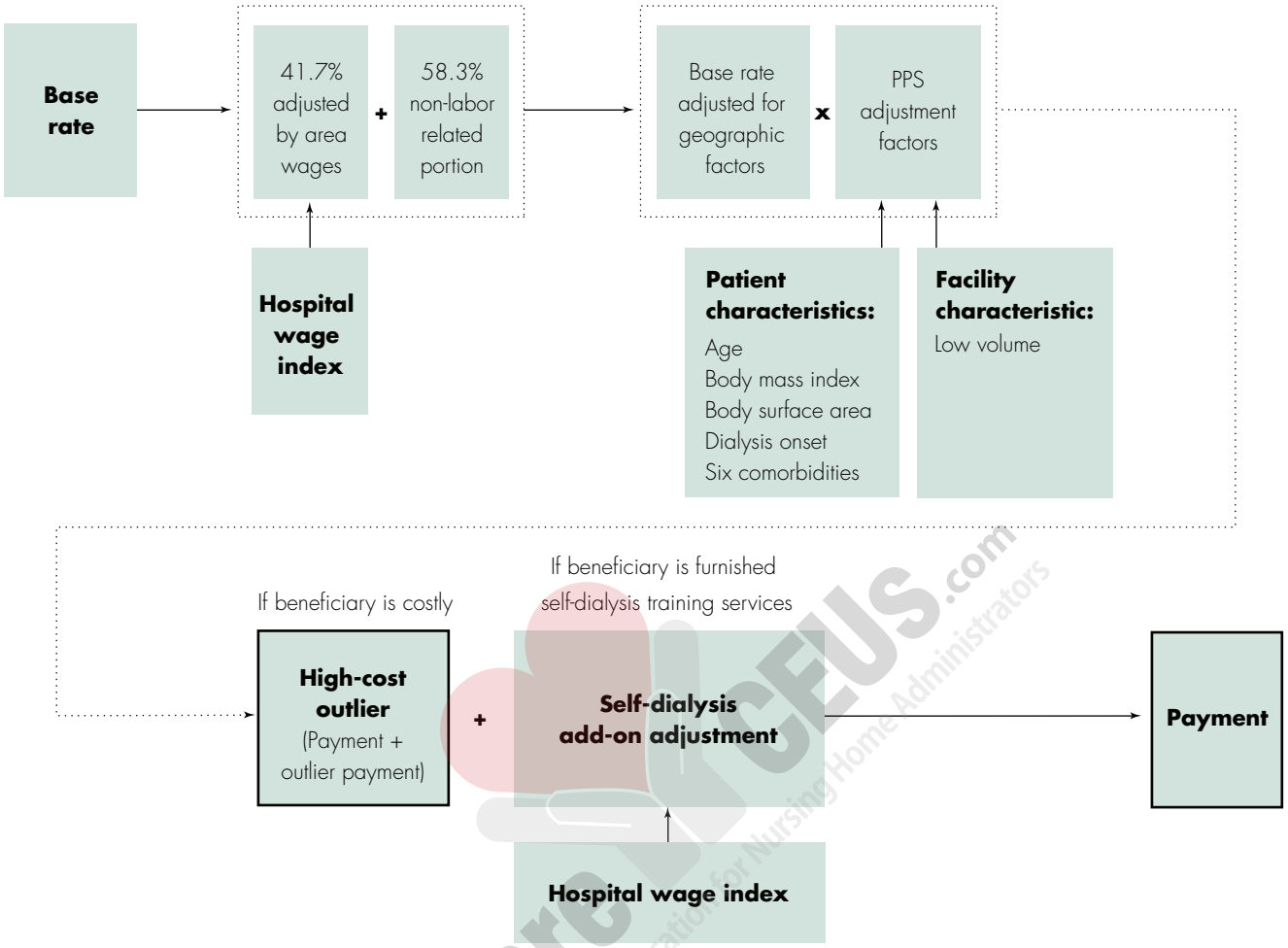
The unit of payment is a single dialysis treatment. Although different equipment, supplies, and labor are needed for hemodialysis and peritoneal dialysis, the payment system that began in 2011 does not differentiate payment based on dialysis method for adults. Medicare's payment rate is based on a regimen of three dialysis treatments per week.

Under the modernized payment method, facilities are paid a single case-mix-adjusted payment which includes composite rate services and ESRD-related drugs, laboratory services, and medical equipment and supplies. The ESRD drugs included under the broader payment bundle include: (1) Part B ESRD-related drugs (including erythropoietin, injectable iron, and vitamin D analogs), and their oral equivalents; and (2) Part D oral ESRD-related drugs with no injectable equivalent (oral-only drugs that include calcimimetics and phosphate binders). The American Taxpayer Relief Act of 2012 (ATRA) delays the inclusion of oral-only ESRD-related drugs into the payment bundle until 2016.

Setting the base rate

The base payment under the broader bundle is intended to cover all operating and capital costs that efficient providers would incur in furnishing dialysis treatment episodes in dialysis facilities or in patients' homes. For 2014, the proposed base payment rate is $239.02 for

Figure 1 Dialysis prospective payment system in 2014



Note: This figure represents the payment method for beneficiaries 18 and older. For beneficiaries under 18: (1) the base rate, adjusted for geographic factors, is multiplied by patient case-mix characteristics (age and dialysis method); (2) the low-volume adjustment factor does not apply; and (3) the outlier payment policy and add-on for self-dialysis training do apply.

Source: MedPAC analysis of CMS's final rule for the end-stage renal disease prospective payment system for calendar year 2014 and the quality incentive program for payment year 2016.

freestanding facilities and for hospital-based facilities (Figure 1). The base rate reflects: (1) a 2.8 percent update relative to the 2013 base rate; and (2) a drug utilization adjustment of $8.16 per treatment. MIPPA mandates that the base rate be annually increased by the rate of increase in the ESRD market basket, reduced by a productivity adjustment. ATRA mandates that the Secretary rebase the outpatient dialysis payment rate in 2014 to reflect the reduction in the use of ESRD-related drugs between 2007 and 2012. CMS will phase in the drug utilization adjustment of $29.93 per treatment over a 3- to 4-year transition period. For payment years 2014 and 2015, CMS will implement the drug utilization adjustment by offsetting the payment update and other impacts by a portion

of the drug utilization reduction amount necessary to create an overall impact of zero percent compared to the previous year's payments.

Patient-level adjustments—For adults, CMS adjusts the base rate for case mix using the following measures:

- age (18–44, 45–59, 60–69, 70–79, ≥80 years),
- two body measurement variables—body surface area and body mass index,
- six specific acute and chronic comorbidities, and
- onset of dialysis (for the first four months a patient receives dialysis).

For children under the age of 18 years, CMS adjusts the base rate by age and dialysis modality.

Facility-level adjustments—CMS includes two facility-level adjustments to the base rate. First, CMS adjusts the base rate for differences in local input prices by using the Office of Management and Budget's Core-Based Statistical Areas. The wage index values used under the ESRD PPS are the inpatient PPS wage index values calculated without regard to geographic reclassifications and utilize pre-floor hospital data that are unadjusted for occupational mix. The labor-related portion of the composite rate is 41.7 percent for both freestanding and hospital-based facilities.

Second, CMS includes an 18.9 percent adjustment to account for the costs that low-volume facilities incur. A low-volume facility is defined as one that furnishes fewer than 4,000 treatments in each of the three years before the payment year and that has not opened, closed or received a new provider number due to a change in ownership during the three-year period. In addition, for new facilities that are Medicare-certified after 2011, CMS considers the facility's proximity to other commonly-owned facilities.

Outlier payments—Under the modernized system, CMS pays facilities an outlier payment when a beneficiary's payment per treatment for outlier services exceeds a threshold, which is the beneficiary's predicted payment amount per treatment for the outlier services plus a fixed dollar loss amount. Outlier services include drugs, laboratory services, and other items that facilities separately billed under the old payment method. The fixed dollar loss amount for 2014 is $98.67 for adults. Medicare pays 80 percent of the facilities' costs above the threshold.

Self-dialysis training add-on payment

The modernized payment method includes a dialysis training add-on payment of $50.16 per treatment that is adjusted based on the same hospital wage index used to adjust the base payment rate. CMS pays up to 15 training sessions for peritoneal dialysis and 25 sessions for hemodialysis.

Transitioning to the modernized payment method

The four-year transition to the new payment method began in 2011. Beginning on January 1, 2014, all facilities will be paid 100 percent under the modernized payment system.

Payment updates

There is a mechanism in the law that annually updates payments to outpatient dialysis facilities. For 2014, the base payment rate was updated by the ESRD market basket, which measures the price increases of goods and services facilities buy to produce patient care, reduced by a productivity adjustment.

Quality incentive payment program

The modernized payment also includes a quality incentive payment program. Quality measures will include anemia management and dialysis adequacy. Beginning in 2012, the bundled payment rate is reduced by up to 2 percent for facilities that do not achieve or make progress toward specified quality measures. Facility-level scores are publicly

Table 1 Key features of the prior dialysis payment method and the modernized prospective payment method

Payment method feature	Prior payment method	Modernized payment method
Payment bundle	Composite rate services, which include: nursing, dietary counseling and other clinical services, dialysis equipment and supplies, social services, and certain laboratory tests and drugs	• Composite rate services • Separately billable (Part B) injectable dialysis drugs and their oral equivalents • ESRD-related laboratory tests • Selected ESRD Part D drugs • Self-dialysis training services
Unit of payment	Single dialysis treatment	Single dialysis treatment
Add-on payment to the composite rate	Yes	None
Self-dialysis training services adjustment	Yes	Yes
Beneficiary-level adjustments	• For adults: age, body surface, and body mass • For pediatric beneficiaries: none	• For adults: age, dialysis onset, body surface, body mass, 6 comorbidities • For pediatric patients: age, dialysis method
Facility-level adjustments	Wage index	• Wage index • Low-volume adjustment
Outlier policy	None	Applies to the portion of the broader payment bundle composed of the drugs and services that were previously separately billable
Quality incentive program	None	For 2014, 4 clinical measures assess the quality of care and 3 reporting measures assess the use of ESRD processes of care.

Note: ESRD (end-stage renal disease). The low-volume adjustment does not apply to pediatric patients.

Source: MedPAC analysis of CMS 2011, CMS 2012, and CMS 2013 final ESRD rules and CMS 2014 final ESRD rule.

reported on-line and posted within dialysis facilities. For the 2014 payment year, the ESRD quality incentive program includes seven measures:

- A clinical measure that assesses dialysis adequacy—the percentage of in-center hemodialysis beneficiaries with an average urea reduction ratio greater than 65 percent;
- A clinical measure that assesses anemia management—the percentage of beneficiaries receiving erythropoietin stimulating agents with an average hemoglobin greater than 12.0 g/dL;
- Two clinical measures that assess hemodialysis vascular access—use of autogenous AV fistulas and intravenous catheters;
- A reporting measure that assesses facility participation in the Centers for Disease Control and Prevention's National Healthcare Safety Network Dialysis event reporting system;
- A reporting measure that assesses facility administration of the in-center hemodialysis Consumer Assessment of Healthcare Providers and Systems Survey instrument (which collects patient satisfaction information); and
- A reporting measure that assesses whether facilities attest to monitoring patients' mineral metabolism (phosphorus and calcium) levels on a monthly basis. ■

OUTPATIENT HOSPITAL SERVICES PAYMENT SYSTEM

Medicare beneficiaries receive a wide range of services in hospital outpatient departments, from injections to complex procedures that require anesthesia. Spending for these services has grown rapidly, largely because of changes in technology and medical practice that have led to new services and encouraged shifts in care from inpatient to ambulatory care settings. Outpatient hospital care accounted for $35 billion of total Medicare program spending in 2012.

Medicare originally based payments for outpatient care on hospitals' costs, but the Centers for Medicare & Medicaid Services (CMS) began using the outpatient prospective payment system (OPPS) in August 2000. In 2013, about 3,900 hospitals provided OPPS services,[1] and about 47 percent of fee-for-service beneficiaries received at least one OPPS service.

Under the cost-based system that preceded the OPPS, coinsurance had become nearly 50 percent of Medicare payments to hospitals for outpatient care. Under the OPPS, coinsurance declines each year as a share of total OPPS payments until it reaches 20 percent. In 2012, beneficiaries' copayments accounted for 22 percent of total payments under the OPPS.

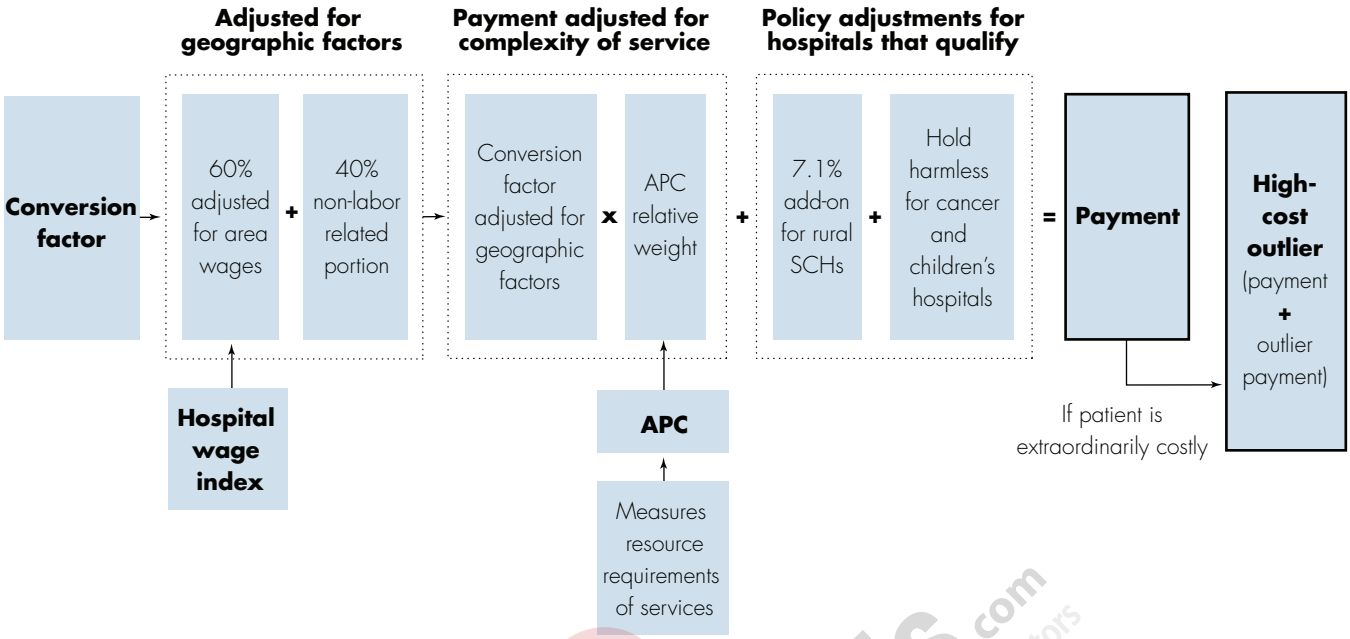
The OPPS sets payments for individual services using a set of relative weights, a conversion factor, and adjustments for geographic differences in input prices. Hospitals also can receive additional payments in the form of outlier adjustments for extraordinarily high-cost services and pass-through payments for some new technologies.

When CMS began using the OPPS, the new payment system had the potential to substantially reduce hospital payments below the amounts under the cost-based system. In response, the Congress partially protected hospitals that experienced financial losses by providing "transitional corridor" and "hold harmless" provisions. The Congress has legislated permanent hold-harmless status to cancer and children's hospitals. In addition, beginning in 2006, rural sole community hospitals (SCHs) receive an additional 7.1 percent above standard payment rates on all OPPS services except drugs and biologicals. Also, beginning in 2012, cancer hospitals receive proportional adjustments to their OPPS payment rates so that the ratio of OPPS payments to OPPS costs (the payment-to-cost ratio (PCR)) for each cancer hospital is equal to the average PCR among all other hospitals providing services under the OPPS.

Defining the outpatient hospital products that Medicare buys

The unit of payment under the OPPS is the individual service as identified by Healthcare Common Procedure Coding System codes. CMS classifies services into ambulatory payment classifications (APCs) on the basis of clinical and cost similarity. All services within an APC have the same payment rate. In addition, CMS assigns some new services to "new technology" APCs based only on similarity of resource use. CMS chose to establish new technology APCs because some services were too new to be represented in the data the agency used to develop the initial payment rates for the OPPS. Services remain in these APCs for two to three years, while CMS collects the data necessary to develop payment rates for them. Each year CMS determines which new services, if any, should be placed in new technology APCs. Payments for new technology APCs are not subject to budget neutrality adjustments, so they increase total OPPS spending.

Figure 1 Hospital outpatient services prospective payment system



Note: APC (ambulatory payment classification), SCH (sole community hospital). The APC is the service classification system for the outpatient prospective payment system.

Within each APC, CMS packages integral services and items with the primary service. In deciding which services to package, CMS considers comments from hospitals, hospital suppliers, and others. In response to these comments, CMS pays separately for:

- corneal tissue acquisition costs,
- blood and blood products, and
- many drugs.

In 2008, CMS expanded the list of services—including observation services—that are packaged into the payment for the associated primary service. The intent of this expanded packaging was to give hospitals more incentive to consider the cost of the package of services used to treat a patient during an outpatient visit. Under greater packaging, hospitals whose costs exceed the payment rate for a package of services have an incentive to evaluate their treatment methods to identify lower cost alternatives for providing care.

While CMS makes most OPPS payments on a per service basis, CMS pays for partial hospitalizations on a per diem basis. The per diem rate represents the expected costs for a day of care in the facilities that provide these services, hospital outpatient departments and community mental health centers.

Setting the payment rates

CMS determines the payment rate for each service by multiplying the relative weight for the service's APC by a conversion factor (Figure 1). The relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. CMS pays separately for professional services, such as physician services.

The conversion factor translates the relative weights into dollar payment rates. To account for geographic differences in input prices, CMS adjusts the labor

portion of the conversion factor (60 percent) by the hospital wage index. CMS does not adjust the remaining 40 percent.

CMS initially set the conversion factor so that projected total payments—including beneficiary copayments—would equal the estimated amount that would have been spent under the old payment system, after correcting for some anomalies in statutory formulas.

One exception to CMS's method for setting payment rates is the new technology APCs. Each new technology APC encompasses a cost range, the lowest being for services that cost $0 to $10, the highest for services that cost $9,500 to $10,000. CMS assigns services to new technology APCs on the basis of cost information collected from applications for new technology status. CMS sets the payment rate for a new technology APC at the midpoint of its cost range.

Hospitals can receive three payments in addition to the standard OPPS payments:

- pass-through payments for new technologies,
- outlier payments for unusually costly services, and
- hold-harmless payments for cancer hospitals and children's hospitals.

In addition to new technology APCs, pass-through payments are another way that the OPPS accounts for new technologies. In contrast to new technology APCs—which are payments for individual services—pass-through payments are for specific drugs, biologicals, and devices that providers use in the delivery of services. The purpose of pass-through payments is to help ensure beneficiaries' access to technologies that are too new to be well represented in the data that CMS uses to set OPPS payment rates. For pass-through devices, CMS bases payments on each hospital's costs, determined by adjusted charges to costs using a cost-to-charge ratio.

Total pass-through payments cannot be more than 2 percent of total OPPS payments in 2004 and beyond. Before the start of each calendar year, CMS estimates total pass-through spending. If this estimate exceeds 2 percent of estimated total OPPS payments, the agency must reduce all pass-through payments in that year by a uniform percentage to meet the 2 percent threshold. Also, CMS adjusts the conversion factor to make pass-through payments budget neutral.

CMS makes outlier payments for individual services that cost hospitals much more than the payment rates for the services' APC groups. In 2013, CMS defines an outlier as a service with costs that exceed 1.75 times the APC payment rate and exceed the APC payment rate by at least $2,025. For a service meeting both thresholds, CMS will reimburse the hospital for 50 percent of the difference between the cost of furnishing the service and 1.75 times the APC rate. For 2013, CMS is limiting aggregate outlier payments to 1 percent of total OPPS payments. CMS will make the outlier payments budget neutral by reducing the conversion factor in the OPPS by 1 percent.

The OPPS has permanent hold-harmless status for cancer and children's hospitals. If PPS payments for these hospitals are lower than those they would have received under previous policies, CMS provides additional payments to make up the difference. Also, CMS makes hospital-specific proportional adjustments to the OPPS payment rates received by cancer hospitals so that the PCR of each cancer hospital equals the average PCR among all other hospitals that provide services under the OPPS. Finally, CMS adds 7.1 percent to the OPPS payments for services furnished by rural SCHs beginning in 2006, excluding drugs and biologicals. CMS makes these additional payments to cancer hospitals and rural SCHs budget neutral by applying the same proportional reduction to payments for all other hospitals.[2]

CMS reviews and revises the APCs and their relative weights annually. The review considers changes in medical

practice, changes in technology, addition of new services, new cost data, and other relevant information. The Balanced Budget Refinement Act of 1999 requires CMS to consult with a panel of outside experts as part of this review. CMS also annually updates the conversion factor by the hospital market basket index minus a multi-factor productivity adjustment.[3]

Drugs and biologicals whose costs exceed a threshold ($80 per day in 2013) have separate APCs; these separately paid drugs and biologicals do not receive outlier payments. ■

1 The number of hospitals providing services under the OPPS differs between this document and Chart 7-11 of MedPAC's June 2013 Data Book because we include all hospitals in this document while our data book is limited to short-term hospitals.

2 For cancer hospitals, CMS first determines their OPPS payments with the additional payments then determines their hold-harmless payments based on those augmented payments.

3 For 2012 through 2019, the Patient Protection and Affordable Care Act adds an additional deduction to the update. In 2013, the additional deduction is 0.1 percent

OUTPATIENT THERAPY SERVICES PAYMENT SYSTEM

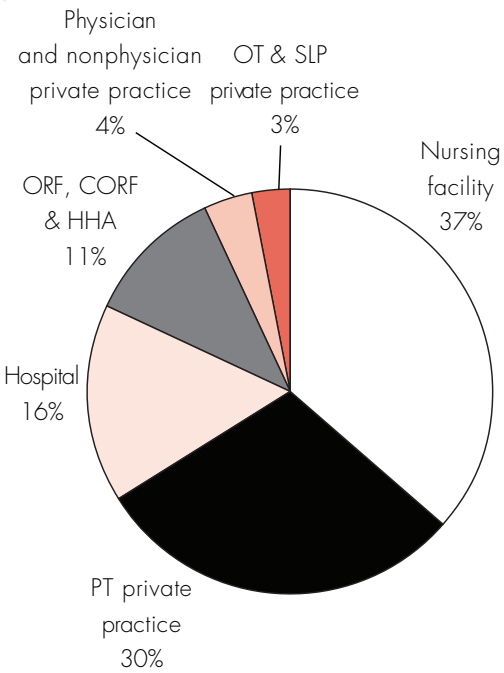
Outpatient therapy services include three separate categories of services that aim to improve and restore function that patients have lost after an illness or injury and to help patients maintain improved function: physical therapy (PT), occupational therapy (OT), and speech–language pathology (SLP) services. PT services include therapeutic exercise, manual therapy, patient education, and other interventions to improve strength and mobility, restore and maintain function, and increase independence. Examples of outcomes include improved ability to stand, lift, carry, and walk independently. OT services are aimed at improving a patient's ability to perform activities of daily living, such as bathing, dressing, and managing medications. Therapies may focus on motor skills, lifting, bending, feeding, and time management. SLP services help patients restore and maintain the ability to communicate, swallow, and speak. For example, a patient who has had a stroke may receive SLP services to recover the ability to speak. SLP services include guided drills and training to improve speech and swallowing functions.

Medicare covers outpatient therapy services if the beneficiary's need for therapy is documented in a written treatment plan developed by the therapist, a physician, or a nonphysician practitioner (NPP) after consultation with a qualified therapist. A physician or NPP must certify the plan of care every 90 days. The prescribed course of therapy must be reasonable and necessary to treat the individual's illness or injury. Among other requirements, covered therapy services must qualify as skilled therapy services that are appropriate for effective treatment of the patient's condition.

Medicare spending on outpatient therapy services was $5.7 billion in 2011, with services provided to 4.9 million beneficiaries. PT services accounted for 72 percent of all spending on therapy services, while occupational therapy and speech–language pathology services accounted for 19 percent and 9 percent, respectively.

Outpatient therapy is furnished in many different settings, including therapists in private practice, nursing homes, hospital outpatient departments, physicians' offices, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities (CORFs), and home health agencies. Outpatient therapy services provided in nursing homes and by physical therapists in private practice account for about two-thirds of Medicare therapy spending, with hospital outpatient

Figure 1 Distribution of outpatient therapy spending by setting, 2011



Note: PT (physical therapist), ORF (outpatient rehabilitation facility), CORF (comprehensive outpatient rehabilitation facility), HHA (home health agency), OT (occupational therapy), SLP (speech–language pathology).

Source: MedPAC analysis of 100 percent Medicare Part B claims, 2011.

departments accounting for 16 percent in 2011 (Figure 1).

Medicare covers therapy services furnished by physicians or by physical therapists, occupational therapists, and speech–language pathologists in their respective disciplines. Medicare also covers therapy services furnished by physician assistants, nurse practitioners, and clinical nurse specialists if permitted by the state in which the provider practices. Qualified physical and occupational therapy assistants may also provide therapy services when supervised by a physical or occupational therapist. Athletic trainers, chiropractors, nurses, and nurse aides do not meet the qualification and training requirements for therapists and therefore can not bill Medicare for therapy services.

Defining the services Medicare pays for

The unit of payment is each individual outpatient therapy service. All services are classified and reported to CMS according to the Healthcare Common Procedure Coding System (HCPCS). Most physical therapy and occupational therapy HCPCS codes are defined in 15-minute increments, but most speech–language pathology services are not.

Setting the payment rates

Medicare pays for outpatient therapy under Medicare's fee schedule for physicians and other health professionals, regardless of where the services are provided.

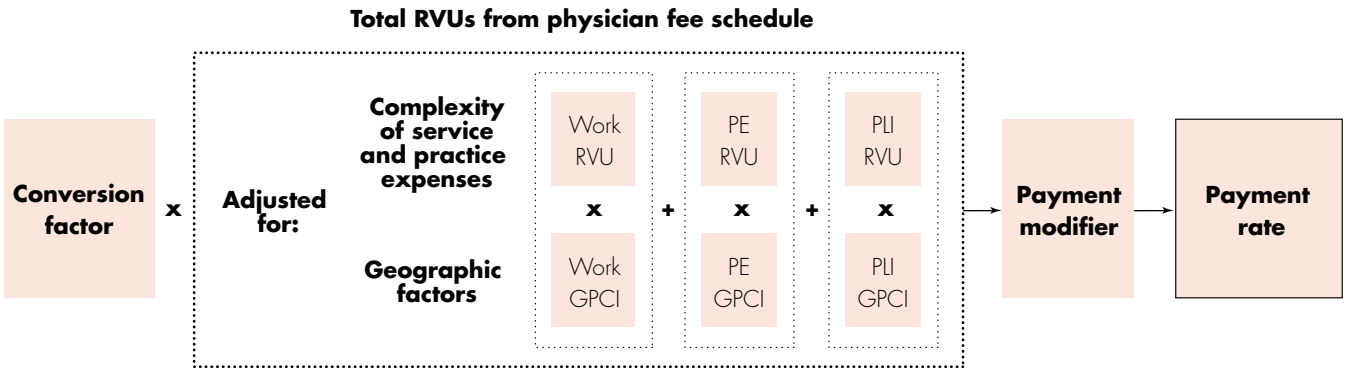
Under the fee schedule, each code has a separate payment rate that is based on a relative weight, expressed as relative value units (RVUs), which account for the relative costliness of the inputs used to provide the service: the clinician's work, practice expenses, and professional liability insurance (PLI). The RVUs for the clinician's work reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for practice expense are based on the expenses providers incur when they rent office space, buy supplies and equipment, and hire nonclinical and administrative staff. The PLI RVUs are based on the premiums providers pay for professional liability insurance.

In calculating a payment rate for each service, each of the three RVUs is adjusted to reflect the prices of inputs in the local market where the service is furnished. Separate geographic practice cost indexes (GPCIs) are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by a standard dollar amount (the conversion factor) (Figure 2). Medicare pays the provider 80 percent of the fee schedule amount, and the beneficiary is liable for the remaining 20 percent coinsurance. Through payment modifiers, Medicare may adjust its payments upward or downward to reflect various factors. For example, Medicare applies a multiple procedure payment reduction to the practice expense component of therapy services when multiple services are furnished by the same provider to the same patient on the same day. When this occurs, CMS reduces the practice expense payment for the second and subsequent therapy services by 50 percent. The rationale for this policy is that efficiencies in practice expense occur when multiple therapy services are furnished in a single session because certain clinical staff activities are not performed twice.

Updating payments

Although the statute requires a review of the fee schedule RVUs every five years, CMS, starting in 2012, is reviewing the RVUs annually. HCPCS codes and the conversion factor are also updated annually. The update of relative weights includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In completing its review, CMS receives advice from a group of physicians and other professionals sponsored by the American

Figure 2 Payment rates for outpatient therapy services



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance). This figure depicts Medicare payments only.

Medical Association and physician specialty societies.

The annual updates for the conversion factor are made according to the sustainable growth rate (SGR) system, a formula intended to keep spending on physician services consistent with a target based on growth in the national economy. The SGR ties payment updates to a number of factors, including growth in input costs, growth in fee-for-service enrollment, and growth in the volume of services relative to growth in the national economy. The *Physician and Other Health Professionals Payment System* document in our "Payment Basics" series provides more information on the SGR.

Outpatient therapy caps

To constrain excessive spending and use, the Congress enacted two caps on annual per beneficiary spending for outpatient therapy services: one for physical therapy and speech–language pathology services combined and another for occupational therapy services. The amount of each cap is $1,900 in 2013. The annual cap amount is unrelated to each patient's condition. Consequently, the cap policy has caused concerns that it could restrict access to medically necessary services. These concerns led the Congress to suspend the caps from 2000 to 2005 (except for a brief period in 2003). In 2006, the caps were reinstated along with an exceptions process.

CMS exceptions process The exceptions process allows beneficiaries to exceed the annual spending cap if the clinician certifies that continued therapy services are medically necessary. Since 2007, the exceptions process has been fully automatic, allowing clinicians to add a modifier to the claim certifying medical necessity. Unlike the caps, the exceptions process periodically expires unless reauthorized by the Congress. The American Taxpayer Relief Act of 2012 (ATRA) extended it through December 31, 2013.

Manual medical review process

The Middle Class Tax Relief and Job Creation Act of 2012 required CMS to conduct manual medical reviews of therapy services for the highest spending beneficiaries—those whose use exceeded $3,700 in spending for physical therapy and speech–language pathology services combined or for occupational therapy. ATRA extended this requirement until December 31, 2013. ■

PART D PAYMENT SYSTEM

In 2006, Medicare began a voluntary outpatient drug benefit known as Part D. A combination of stand-alone prescription drug plans (PDPs) and Medicare Advantage (MA)–Prescription Drug plans (MA–PDs) delivers the benefit. In each of 34 geographic regions, plans compete for enrollees on the basis of annual premiums, benefit structures, specific drug therapies covered, pharmacy networks, and quality of services. Plans bear some risk for their enrollees' drug spending. Overall, Medicare subsidizes premiums by about 75 percent and provides additional subsidies for beneficiaries who have low levels of income and assets.[1] Medicare's payments to plans are determined through a competitive bidding process, and enrollee premiums are tied to plan bids.

The drug benefit

The standard 2014 benefit will include:

- a $310 deductible;
- coverage for 75 percent of allowable drug expenses up to a benefit limit of $2,850;
- a $4,550 catastrophic limit on true out-of-pocket spending[2]; and
- about 5 percent coinsurance for drug spending above the out-of-pocket (OOP) threshold (Figure 1).

Prior to 2011, enrollees with standard benefits were responsible for paying the full cost of drug spending between the initial benefit limit and the out-of-pocket threshold. The Patient Protection and Affordable Care Act of 2010 (PPACA) directed CMS to phase out this coverage gap between 2011 and 2020.[3] Under the standard benefit, cost sharing for both brand and generic drugs will be reduced each year until 2020, when the coverage gap will be eliminated and beneficiaries will pay 25 percent cost sharing for all drugs until they reach the OOP threshold.

Plans can and often do offer alternative coverage structures. For example, a plan can offer a deductible lower than $310, or use tiered copayments rather than coinsurance—provided that the alternative benefit meets certain tests of actuarial equivalence. Also, plans may offer additional drug coverage that supplements the standard benefit. Medicare payments to plans do not subsidize such supplemental coverage.

Under Part D, Medicare provides primary drug coverage for individuals who are dually eligible for Medicare and Medicaid. Dually eligible individuals with incomes up to 100 percent of poverty have no deductibles, nominal copays, and no coverage gap. Beneficiaries who do not qualify for full Medicaid benefits but whose incomes are below 150 percent of poverty and who meet an asset test receive full or partial coverage for premiums and cost sharing and do not face a coverage gap.

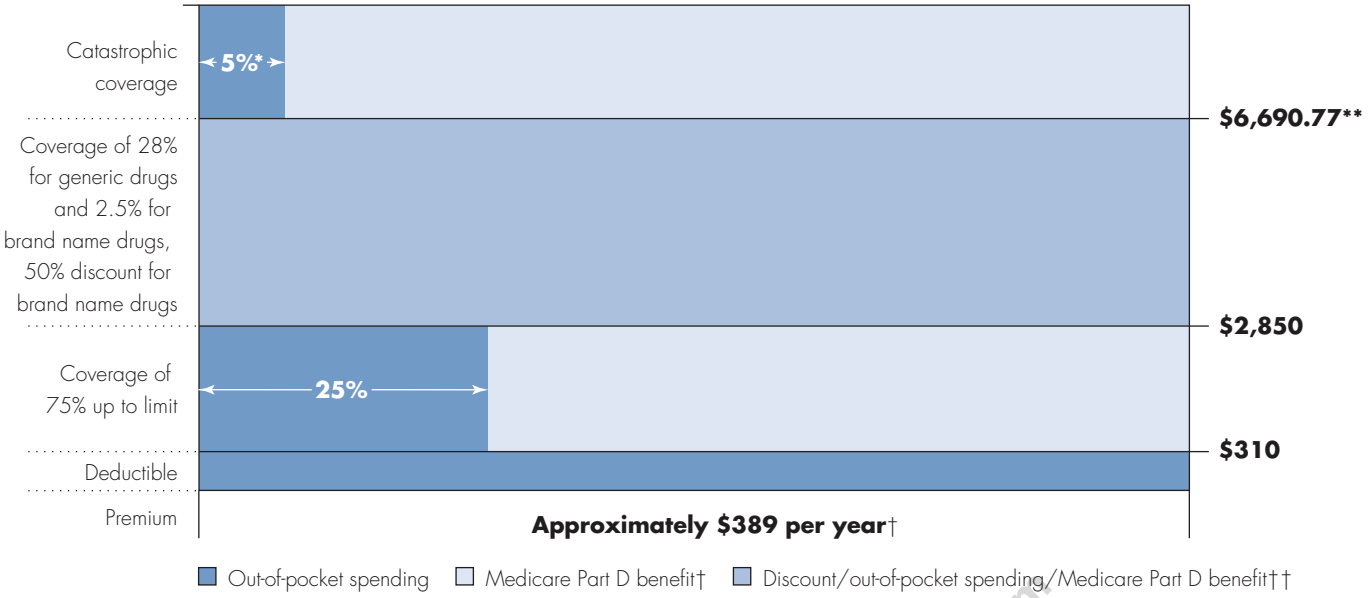
Medicare's subsidy amounts

For each Medicare enrollee in a plan (either stand-alone PDP or MA–PD), Medicare provides plans with a subsidy that averages 74.5 percent of standard coverage for all types of beneficiaries.[1] That average subsidy takes two forms:

- Direct subsidy—a capitated payment to plans calculated as a share of the adjusted national average of plan bids.
- Individual reinsurance—Medicare subsidizes 80 percent of drug spending above the out-of-pocket threshold. Reinsurance acts as a form of risk adjustment by providing greater federal subsidies for the highest cost enrollees.

In addition, Medicare establishes symmetric risk corridors separately for each plan to limit a plan's overall losses or profits. Under risk corridors, Medicare

Figure 1 Standard drug benefit in 2014



Note: Benefit structure applicable to an enrollee who has no supplementary drug coverage.
* Cost sharing above the out-of-pocket (OOP) threshold is the greater of either 5 percent coinsurance or a copay of $2.55 for generic drugs, or $6.35 for brand name drugs.
**Equivalent to $4,550 in OOP spending: $310 (deductible) + $635 (25% cost sharing on $2,540) + $3,605 (72% cost sharing for generic drugs, 47.5% cost sharing for brand name drugs, and 50% manufacturer discount for brand name drugs in the "coverage gap"). The amount of total covered drug spending at which a beneficiary meets the annual OOP threshold depends on the mix of brand name and generic drugs that the individual fills during the coverage gap. The estimated amount of total drug expenses at the annual OOP threshold for 2014 ($6,690.77) is for an individual, not receiving Part D's low-income subsidy (LIS), who has no other sources of supplemental coverage.
†There is a base beneficiary premium of $389 per year, which is 25.5% of expected Medicare Part D benefits per person, but the actual premiums that beneficiaries pay vary by plan. Federal subsidies pay for the remainder of covered Part D benefits.
††In 2014, cost sharing for drugs filled during the coverage gap will be 72% for generic drugs (the remaining 28% will be picked up by the Part D benefit) and about 47.5% for brand name drugs. The actual cost sharing amount for brand name drugs will depend on the amount of dispensing fee charged by a plan since the 2.5% covered by the Part D benefit applies to both the ingredient cost and the dispensing fee, while the 50% manufacturer discount applies only to the ingredient cost.

limits a plans' potential losses (or gains) by financing some of the higher-than-expected costs (or recouping excessive profits). These corridors could be widened in the future, meaning that plans could bear more insurance risk than they currently do. Also, Medicare pays plans that enroll low-income beneficiaries most of their enrollees' cost sharing and premiums.

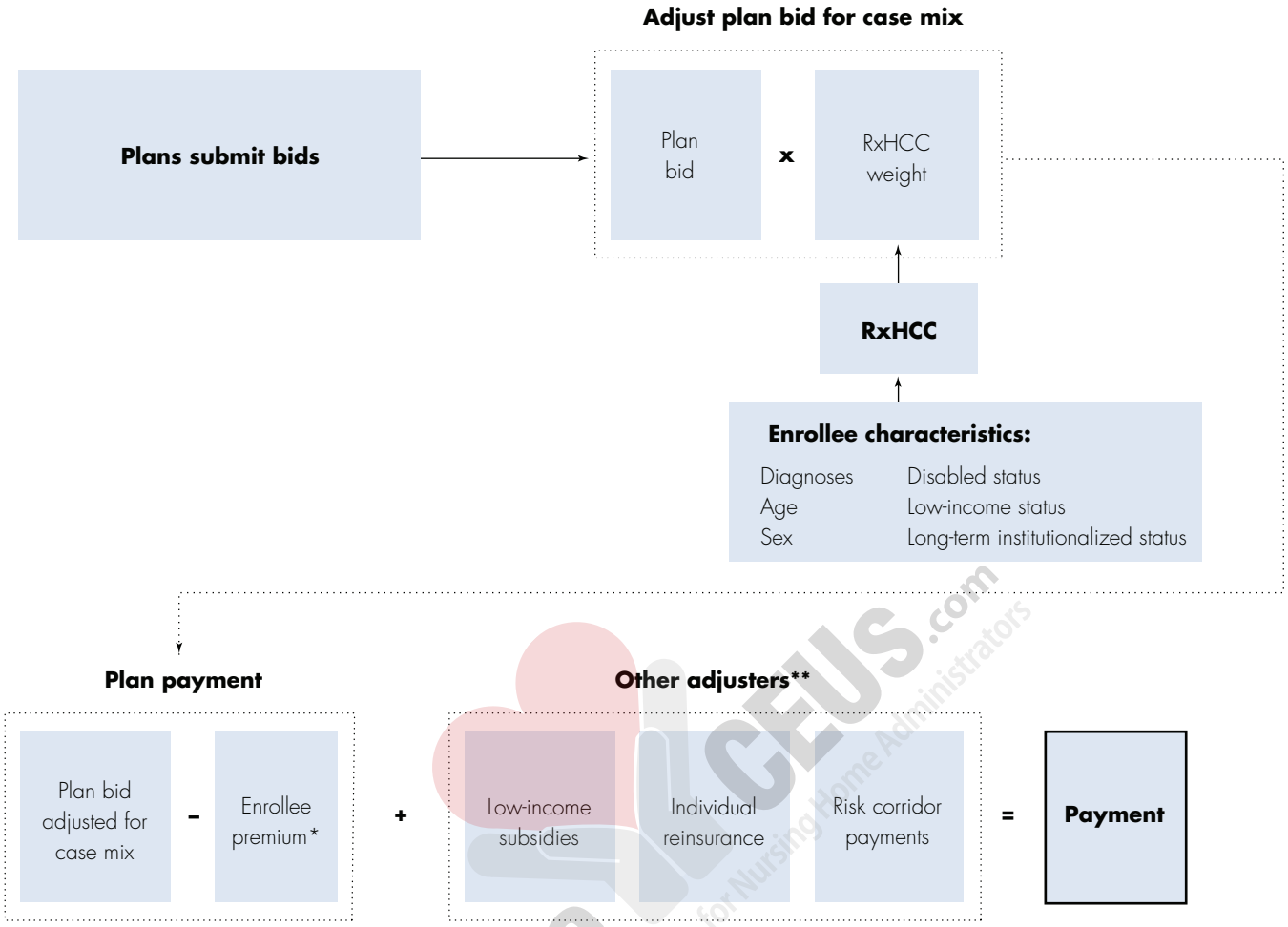
Note that although plans get essentially the same level of direct subsidy per enrollee (modified by risk adjusters), the level of subsidies granted through the other three mechanisms differ substantially from plan to plan. Subsidy dollars vary depending on the characteristics of individuals that each plan enrolls (e.g., income and health status), as well as whether a plan's losses or profits trigger provisions of its risk corridors.

Part D replaced Medicaid as the primary source of prescription drug coverage for individuals who are dually eligible for Medicare and Medicaid. However, states continue to help finance the costs of drug coverage for dually eligible beneficiaries by making monthly lump sum payments to Medicare.

Medicare's payments to plans

Each plan submits bids annually to the Centers for Medicare & Medicaid Services (CMS) by the first Monday in June. Those bids should reflect the plan's expected benefit payments plus administrative costs after they deduct expected federal reinsurance subsidies. Plans base their bids on expected costs for a Medicare beneficiary of average health; CMS then

Figure 2 Part D payment system



Note: RxHCC (prescription drug hierarchical condition category). The RxHCC is the model that estimates the enrollee risk adjuster. Beginning in 2011, CMS replaced its single model of risk scores with five separate sets of model coefficients for: long-term institutionalized enrollees; aged low-income enrollees; aged non–low-income enrollees; disabled low-income enrollees; and disabled non–low-income enrollees. Prior to 2011, payments on behalf of beneficiaries with low-income and long-term institutionalized status were adjusted using multipliers intended to reflect those individuals' higher levels of drug spending.
* Figure 3 outlines the process for calculating enrollee premiums.
**Plans receive interim prospective payments for individual reinsurance and low-income subsidies that are later reconciled with CMS.

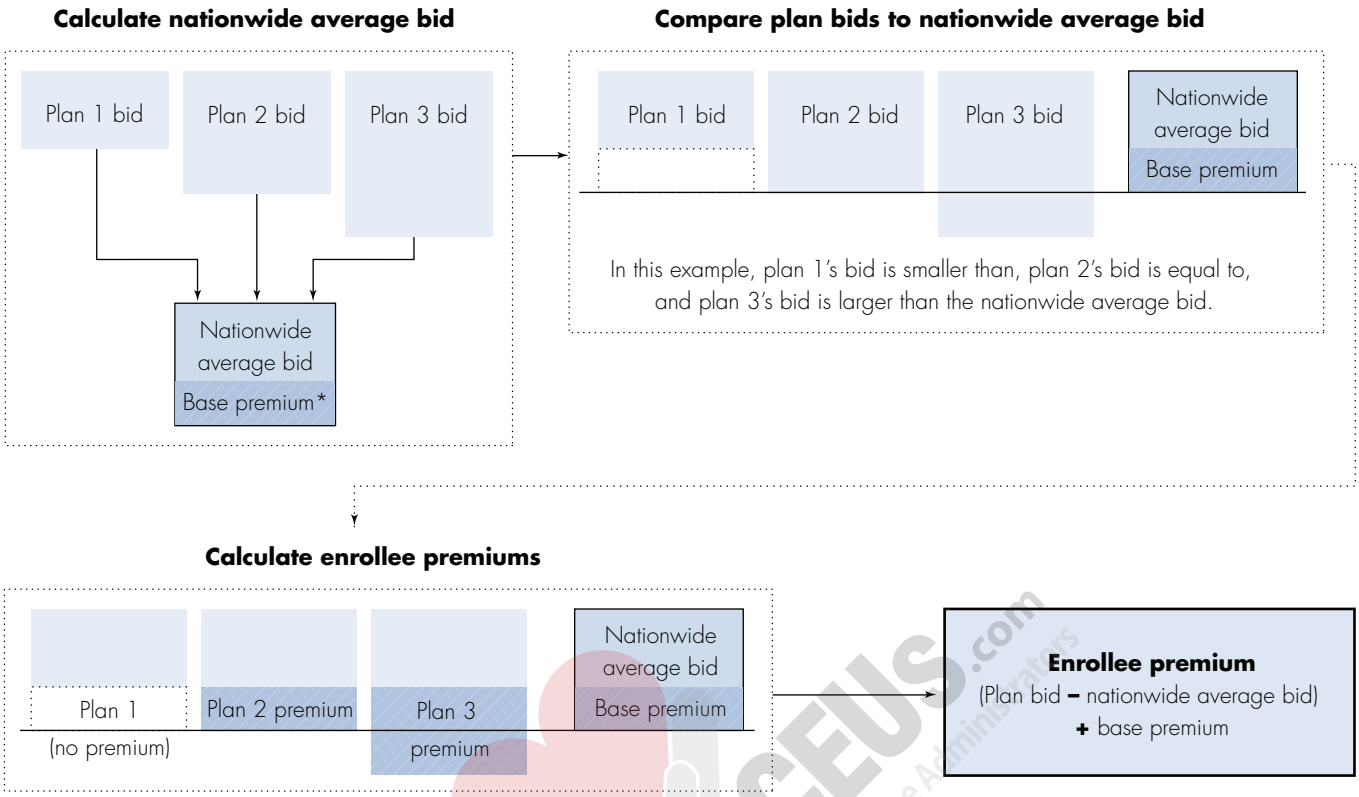
adjusts payments to plans based on the actual health status of the plans' enrollees.

CMS pays plans a monthly prospective payment for each enrollee (the direct subsidy). This payment is first adjusted by the enrollee's case mix and other subsidy factors, namely low-income status and long-term institutionalized status (Figure 2). A second adjustment to the plan's approved bid is the subtraction of the enrollee's premium. (See the following section on how premiums are calculated.) CMS also provides plans with interim prospective payment adjustments for individual reinsurance and low-income subsidies. The agency reconciles actual levels of enrollment, risk factors, levels of incurred allowable drug costs (after rebates and other discounts), reinsurance amounts, and low-income subsidies after the end of each year.

Calculating enrollee premiums

CMS takes plans' standardized bid amounts for basic benefits or the portion

Figure 3 Calculating enrollee premiums



Note: *Base premium is a share of the nationwide average bid. It equals the nationwide average times a factor with a numerator of 25.5% and a denominator of 100% minus CMS's estimate of aggregate plan revenues for Part D benefits that they receive through federal individual reinsurance subsidies. Beginning in 2011, Part D has begun collecting additional premiums from higher income enrollees. The extra premium amount is equal to the difference between 35, 50, 65, or 80% and the 25.5% applied to the nationwide average bid adjusted for individual reinsurance.

of plan bids attributable to basic coverage and calculates the average (Figure 3). From this nationwide average, plan enrollees must pay a base premium plus any difference between their plan's bid and the nationwide average bid.

Individuals with modified adjusted gross incomes exceeding $85,000 ($170,000 for couples) are subject to a reduced premium subsidy similar to the income-related premium under Medicare Part B. The base premium amount for beneficiaries not subject to a reduced premium subsidy is $32.42 in 2014. Enrollees in costlier plans face higher-than-average premiums for standard Part D coverage; similarly, enrollees in less expensive plans pay lower-than-average premiums.[4]

Most low-income beneficiaries do not pay a premium because Medicare pays for their premium up to a regional threshold amount, calculated as an enrollment-weighted average premium for each PDP region. Since enrollees tended to select or were auto-enrolled in plans with lower premiums, using enrollment weights to calculate the regional thresholds has led to fewer premium-free plans available for low-income beneficiaries. As a result, many individuals have had to change plans or pay the portion of the premium that exceeds the regional threshold to remain in the same plan. To reduce the effects of annual changes in plans that qualify as premium-free, the PPACA changed the benchmark calculation methodology to exclude Medicare Advantage rebates.

Benefit and payment updates

Medicare updates the deductible, benefit limit, and catastrophic threshold amounts in the standard Part D benefit each year. Plan payments are a function of plans' updated bids. The benefit's threshold amounts increase by CMS's estimate of the annual change in drug spending per person. ■

1 As a result of changes made by the Patient Protection and Affordable Care Act of 2010 (PPACA), beginning in 2011 the premium subsidy is reduced for higher income beneficiaries. For more information, refer to the section on calculating enrollee premiums.

2 The term "true out-of-pocket" refers to a feature of Part D that directs fewer federal subsidy dollars toward enrollees who have supplemental coverage. Specifically, only certain types of spending on behalf of the beneficiary count toward the catastrophic threshold: the beneficiary's own out-of-pocket (OOP) spending; that of a family member or official charity; and supplemental drug coverage provided through qualifying state pharmacy assistance programs or Part D's low-income subsidies. In addition, beginning in 2011, drug spending made on behalf of the beneficiary by AIDS Drug Assistance Program, the Indian Health Service, and the 50 percent discount paid for by pharmaceutical manufactures for brand name drugs will count toward the OOP threshold. Beneficiaries need to adhere to their plan's formulary, prior authorization, and formulary exceptions processes in order to receive credit for their OOP spending toward the $4,550 limit.

3 PPACA eliminates the coverage gap by: 1) requiring pharmaceutical manufacturers to offer a 50 percent discount on brand name drugs filled during the coverage gap, 2) gradually phasing down cost sharing for generic drugs beginning in 2011, 3) phasing down cost sharing for brand name drugs beginning in 2013, and 4) reducing the OOP threshold on true out-of-pocket spending over the 2014 to 2019 period.

4 Beneficiaries (other than those who receive low-income subsidies) who delay enrolling in Part D until after their initial enrollment period and who do not have creditable coverage must also pay a late enrollment penalty similar to that for Part B. Creditable coverage refers to prescription drug benefits through sources such as a former employer that are at least as generous as the standard Part D benefit.

PHYSICIAN AND OTHER HEALTH PROFESSIONALS PAYMENT SYSTEM

Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. These services are furnished in all settings, including physicians' offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Among the 1 million clinicians in Medicare's registry, approximately half are physicians who actively bill Medicare. The remainder includes health professionals such as nurse practitioners, physician assistants, and physical therapists. These health professionals may bill Medicare independently (accounting for about 11 percent of physician fee schedule spending) or provide services under physician supervision.

Physician services are billed to Part B. Payments for these services (about $67 billion in 2012) account for about 12 percent of total Medicare spending. In 2011, almost all (98 percent) of beneficiaries enrolled in Medicare fee-for-service received at least one physician service.

Medicare pays for physician services based on a list of services and their payment rates, called the physician fee schedule. In determining payment rates for each service on the fee schedule, the Centers for Medicare & Medicaid Services (CMS) considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three types of resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule's conversion factor ($34.02 in 2013), to arrive at the payment amount. Medicare's payment rates may be adjusted based on provider characteristics, additional geographic designations, and other factors. Medicare pays the provider the final amount, less any applicable beneficiary coinsurance. In 2011, the number of distinct services that Medicare paid for under the fee schedule totaled just over 1 billion.

The conversion factor updates payments for physician services every year according to a formula called the sustainable growth rate (SGR) system. This formula is intended to keep spending growth (a function of service volume growth) consistent with growth in the national economy. However, in the last several years, the Congress has specified an update outside of the SGR formula.

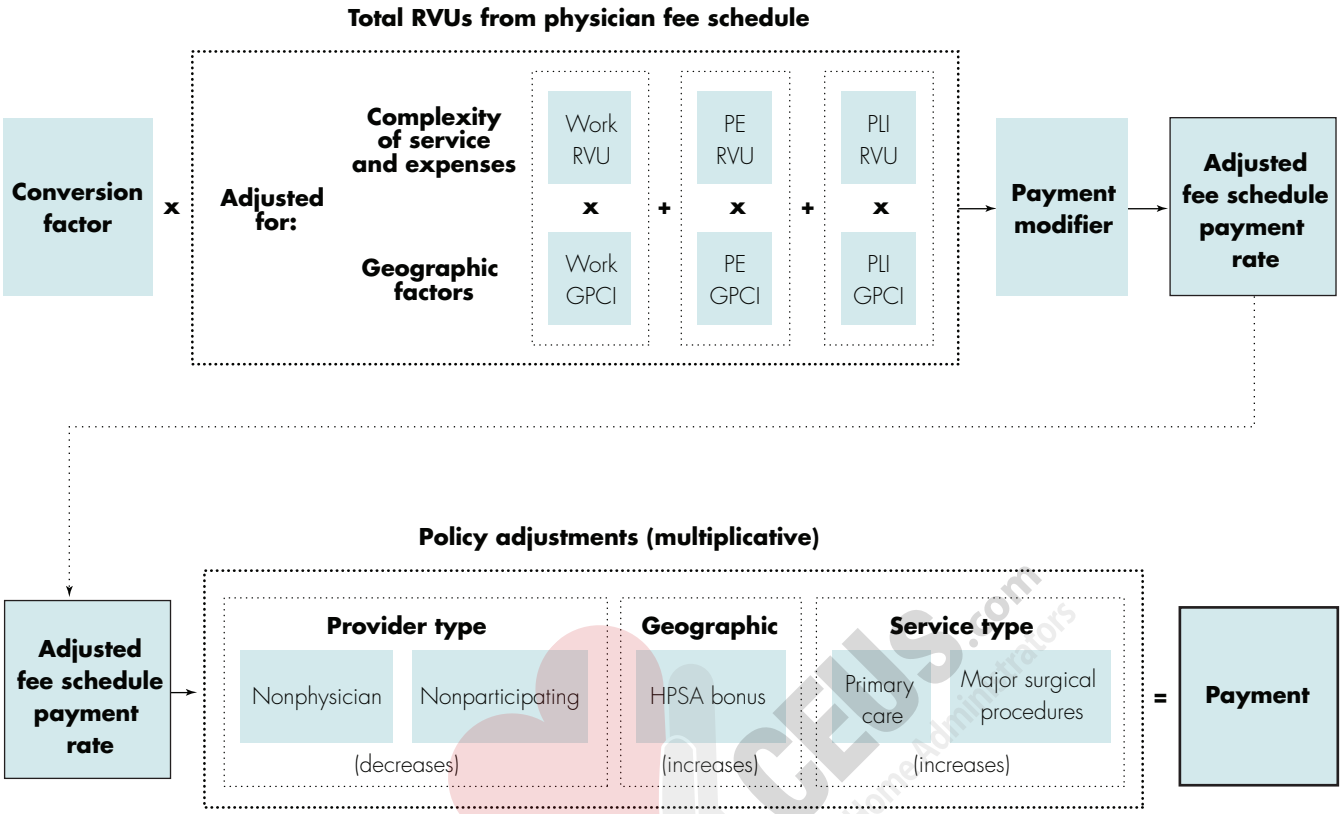
Defining the services Medicare buys

Under the physician fee schedule, the unit of payment is generally the individual service, such as an office visit or a diagnostic procedure. These products, however, range from narrow services (an injection) to broader bundles of services associated with surgical procedures, which include the surgery and related pre-operative and post-operative visits. All services—surgical and non-surgical—are classified and reported to CMS according to the Healthcare Common Procedure Coding System (HCPCS), which contains codes for about 7,000 distinct services.

Setting the payment rates

Under the fee schedule payment system, payment rates are based on relative weights, called relative value units (RVUs), which account for the relative costliness of the inputs used to provide physician services: physician work, practice expenses, and professional liability insurance (PLI) expenses. The RVUs for physician work reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for practice expense are based

Figure 1 Physician services payment system



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance), HPSA (health professional shortage area). This figure depicts Medicare payments only. The physician fee schedule lists separate PE RVUs for facility and nonfacility settings. Fee schedule payments are reduced when specified nonphysician practicioners bill Medicare separately, but not when services are provided "incident to" a physician.

on the expenses physicians incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. The PLI RVUs are based on the premiums physicians pay for professional liability insurance, also known as medical malpractice insurance.

In calculating payment rates, each of the three RVUs is adjusted to reflect the price level for related inputs in the local market where the service is furnished. Separate geographic practice cost indexes (GPCIs) are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by the fee schedule conversion factor (Figure 1). For most physician services, Medicare pays the provider 80 percent of the fee schedule amount. The beneficiary is liable for the remaining 20 percent coinsurance.

Through payment modifiers, Medicare may adjust its payment for a service because of special circumstances. For example, physicians use a modifier to bill for a service when they assist in a surgery; payment for an assistant surgeon is 16 percent of the fee schedule amount for the primary surgeon. Other modifiers apply to multiple surgical procedures performed for the same patient on the same day, preoperative or postoperative management without surgical care, and bilateral surgery.

Payments under the physician fee schedule also may be adjusted upward

or downward to reflect other factors. The first potential downward adjustment occurs if services are furnished by certain nonphysician practitioners. For example, services billed separately and provided by nurse practitioners are paid at 85 percent of physicians' fees. When nonphysician practitioners perform services "incident to" or under direct physician supervision, they may not bill Medicare separately and Medicare pays for the fee schedule amount for the service as if the physician had personally furnished it.

Another instance in which Medicare can adjust fee schedule payments downward occurs when services are furnished by physicians who are not in Medicare's participating physician and supplier program. Payment rates for services provided by nonparticipating physicians are 95 percent of the fee schedule payment rate.

Physicians and other health professionals may receive increases for services they provide in underserved areas. Under the Medicare incentive payment program, physicians receive bonus payments when they provide services in health professional shortage areas (HPSAs). These payments are intended to attract more physicians to HPSAs. The bonus increases payments to these physicians by 10 percent (excluding beneficiary coinsurance).

The Patient Protection and Affordable Care Act (PPACA) established new incentive payments starting in 2011 for two types of services: primary care services and major surgical procedures. The primary care incentive is a 10 percent increase in the payment for services defined in the law as primary care and furnished by an eligible practitioner. The incentive payment for major surgical procedures is also a 10 percent increase. It applies to qualifying services when furnished by an eligible surgeon and furnished in a HPSA. Both incentive payments—for primary care and for major surgical procedures—expire at the end of 2015.

Updating payments

While the statute requires a review of the relative values every five years, CMS, starting in 2012, is reviewing the fee schedule relative values annually. HCPCS codes and the conversion factor are updated annually. The update of relative weights includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In completing its review, CMS receives advice from a group of physicians and other professionals sponsored by the American Medical Association and physician specialty societies.

The annual updates for the conversion factor are made according to the SGR system, a formula intended to keep spending on physician services—a function of service volume—consistent with a target based on growth in the national economy. The SGR ties physician payment updates to a number of factors, including growth in input costs, growth in fee-for-service enrollment, and growth in the volume of physician services relative to growth in the national economy. If actual spending is less than the target, the update is greater than the change in input prices for physician services. If actual spending is greater than the target, the update is less than the change in input prices. For most of the last 10 years, the Congress has specified an update outside of the SGR formula, thereby averting negative updates called for by the SGR. ■

SKILLED NURSING FACILITY SERVICES PAYMENT SYSTEM

Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing facilities (SNFs). Medicare covers up to 100 days of SNF care per spell of illness.[1] Beginning on day 21 of a SNF stay, a beneficiary is responsible for a daily copayment. In 2013, the copayment is $148. SNFs are the most commonly used post-acute care setting. In 2012, Medicare estimates program spending to be $30.4 billion for SNF care.

Skilled nursing facilities can be hospital-based units or freestanding facilities. In 2011, 93 percent of stays were in freestanding facilities. With approval from CMS, certain Medicare-certified hospitals (typically small, rural hospitals and critical access hospitals) may also provide skilled nursing services in the hospital beds used to provide acute care services. These are called swing bed hospitals.

The SNF product and Medicare payment

The Medicare SNF benefit covers skilled nursing care, rehabilitation services and other goods and services and pays facilities a pre-determined daily rate for each day of care. The prospective payment system (PPS) rates are expected to cover all operating and capital costs that efficient facilities would be expected to incur in furnishing most SNF services, with certain high-cost, low-probability ancillary services paid separately.[2] Medicare's PPS for SNF services started on July 1, 1998.[3] Prior to that, SNFs were paid on the basis of their costs, subject to limits on their per diem routine costs (room, board, and routine nursing care); no limits were applied for ancillary services (such as drugs and therapy).

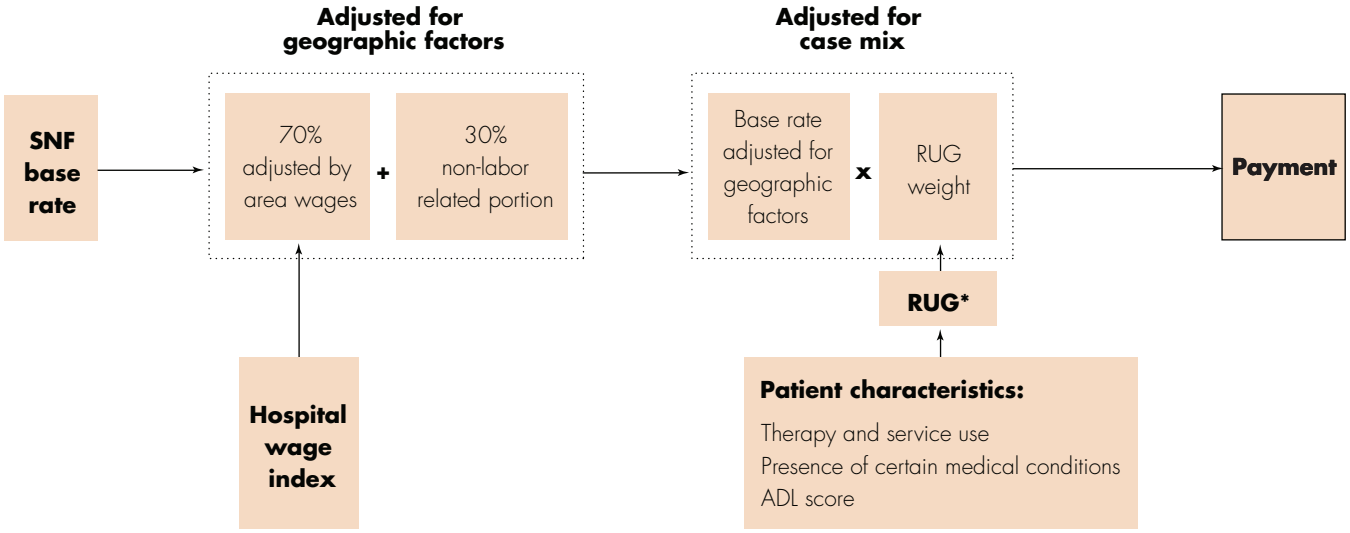
Setting the payment rates

The initial payment rates were set in 1998 to reflect the projected amount that SNFs received in 1995, updated for inflation.[4] The base payment rates were computed separately for urban and rural areas and they are updated annually based on the projected increase in the SNF market basket index, a measure of the national average price level for the goods and services SNFs purchase to provide care. Beginning in 2012, the market basket update is offset by a productivity adjustment, as required by the Patient Protection and Affordable Care Act of 2010. In 2014, for SNFs located in urban areas, the nursing component base rate is $165.81, the therapy component base rate is $124.90, and the other component is a uniform $84.62 (regardless of the case-mix group). In rural facilities, the nursing component base rate is $158.41, the therapy component is $144.01, and the other component is $86.19.

Daily payments to SNFs are determined by adjusting the base payment rates for geographic differences in labor costs and case mix (Figure 1). To adjust for labor cost differences, the labor-related portion of the total daily rate—70 percent for fiscal year 2014—is multiplied by the hospital wage index in the SNF's location and the result is added to the nonlabor portion. The daily base rates are adjusted for case mix using a system known as resource utilization groups (RUGs). Each RUG has associated nursing and therapy weights that are applied to the base payment rates.

A patient's day of care is assigned to one of 66 RUGs based on patient characteristics and service use that are expected to require similar resources. The classification system includes: 14 rehabilitation groups; 9 groups for days with rehabilitation and extensive services (such as ventilator care); 3 groups for extensive services; 16 groups

Figure 1 Skilled nursing facility services prospective payment system



Note: SNF (skilled nursing facility), RUG (resource utilization group), ADL (activity of daily living).
*See Figure 2 for more detail on case-mix adjustment.

for special care (such as patients who have chronic obstructive pulmonary disease); and 10 groups for clinically complex care (such as patients with pneumonia). Days classified into two broad groups—impaired cognition and reduced physical function, which account for 14 groups—are typically not covered by Medicare because the patient does not generally require skilled care. As shown in Figure 2, assignment of a beneficiary to one of the RUGs is based on the number of minutes of therapy (physical, occupational, or speech) that the patient has used or is expected to use; the need for certain services (e.g., respiratory therapy or specialized feeding); the presence of certain conditions (e.g., pneumonia or dehydration); and an index based on the patient's ability to perform independently four activities of daily living (eating, toileting, bed mobility, and transferring). Patients' characteristics and service use are determined by periodic assessments using the SNF patient assessment instrument, known as the Minimum Data Set.

The daily rate is the sum of three components:

- a nursing component, reflecting the intensity of nursing care patients are expected to require.

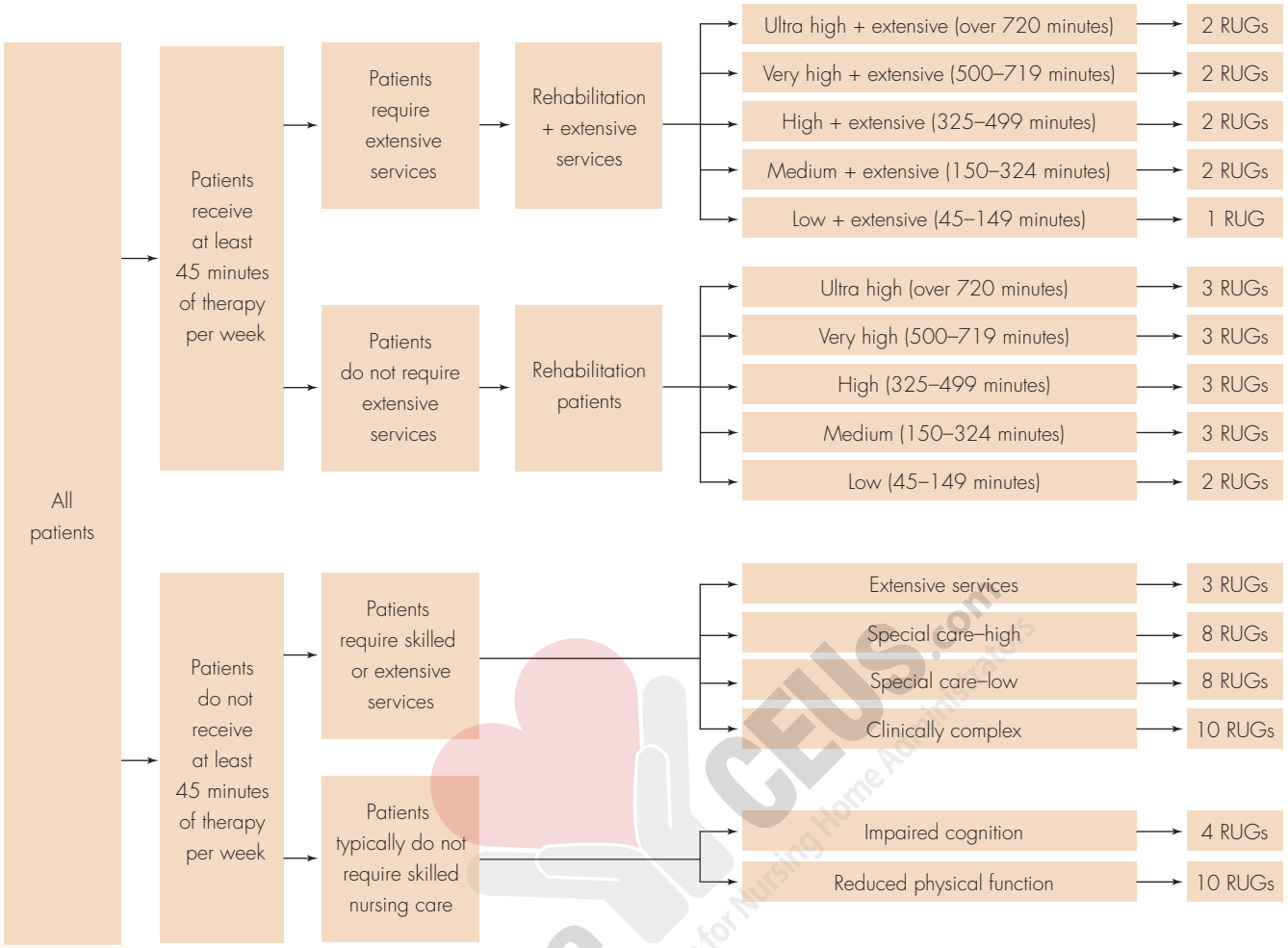
Table 1 Medicare daily base rates for fiscal year 2014

Rate component	Nursing	Therapy (for rehabilitation RUGs)	Therapy* (for nonrehabilitation RUGs)	Other*
Urban rate	$165.81	$124.90	$16.45	$84.62
Rural rate	158.41	144.01	17.57	86.19

Note: RUG (resource utilization group).
*Not case mix adjusted.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. CMS–1446–F. Medicare Program; Prospective payment systems and consolidated billing for skilled nursing facilities for fiscal year 2014. *Federal Register* 78, no. 151 (August 6): 47936–44978.

Figure 2 RUG–IV classification system



Note: RUG–IV (resource utilization group, version IV). Differences between RUGs are based on activity of daily living score, service use, and the presence of certain medical conditions. The extensive services category includes patients who receive tracheostomy care, ventilator or respirator services, or are in isolation for an active infectious disease while a resident. The special care–high category includes patients who are comatose; have quadriplegia, chronic obstructive pulmonary disease, septicemia, diabetes requiring daily injections, fever with specific other conditions; or require parenteral/intravenous feedings or respiratory therapy for 7 days. The special care–low includes patients with cerebral palsy, multiple sclerosis, Parkinson's disease, respiratory failure, a feeding tube, pressure ulcers of specific sizes, foot infections, or who receive radiation therapy or dialysis while a resident. Clinically complex category includes patients who have burns, septicemia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while a resident.

Source: Figure adapted from Government Accountability Office. 2002. *Skilled nursing facilities: Providers have responded to Medicare payments systems by changing practices*, no. GAO–02–841. Washington, DC: GAO.

- a therapy component, reflecting the amount of therapy services provided or expected to be provided; and
- a non-case mix adjusted component reflecting the costs of room and board, linens, and administrative services.

The nursing component is case-mix adjusted for all RUGs. The therapy component is case-mix adjusted for rehabilitation RUGs and is a constant amount for nonrehabilitation RUGs. The payment for room and board is a constant amount for all RUGs. Medicare's daily base rates, unadjusted for case mix or wage differences, for fiscal year 2014 are shown in Table 1.

Starting October 1, 2004, SNFs receive a 128 percent increase in the Medicare PPS per diem payment for SNF patients with AIDS. This temporary add-on remains in effect until the Secretary certifies that the case-mix system makes appropriate adjustment for the costs of AIDS patients. ■

1 A spell of illness begins with the first day of a hospital or SNF stay and ends when there has been 60 consecutive days during which a patient was not in a hospital or a SNF.

2 The following services are excluded from the SNF PPS when furnished on an outpatient basis by a hospital or critical access hospital: cardiac catheterization, computed axial tomography, magnetic resonance imaging, radiation therapy, ambulatory surgery involving the use of a hospital operating room, emergency services, angiography services, lymphatic and venous procedures, and ambulance services used to transport a beneficiary to a facility to receive any of these services. In addition, the following services must be billed separately: physician and other services billed under the physician fee schedule, erythropoietin for certain dialysis patients, dialysis-related ambulance transportation, hospice care related to a terminal illness, radioisotope services, certain chemotherapy services, and certain customized prosthetic devices.

3 On July 1, 2002, Medicare began paying swing bed hospitals that are not critical access hospitals according to the SNF prospective payment system. Critical access hospitals continue to be paid for their swing beds based on their costs of providing care.

4 By law, this projection excluded costs of SNFs that were exempt from Medicare's routine cost limits and costs related to payments for exceptions to the routine cost limits. In 1995, it included only 50 percent of the difference between the average costs of hospital-based and freestanding facilities.

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