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# CRS Report for Congress

## Medicare Payment Policies

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# Medicare Payment Policies


## Summary

Medicare is the nation's health insurance program for the aged, disabled, and persons with End Stage Renal Disease (ESRD). Part A of the program, the Hospital Insurance program, covers hospital services, post-hospital services, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of complementary medical services including physician, laboratory, outpatient hospital services, and durable medical equipment. Part C provides managed care options for beneficiaries who are enrolled in both Parts A and B. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added Part D to Medicare, which provided a new outpatient prescription drug benefit starting January 1, 2006.

Medicare has established specific rules for payment of covered benefits under Parts A, B, and C. Some, such as physician services and most durable medical equipment, are based on fee schedules. Some payments are based, in part, on a provider's bid (an estimate of the cost of providing a service) relative to a benchmark (the maximum amount Medicare is willing to pay). Bids and benchmarks are used to determine payments in Medicare Part C and some items of durable medical equipment in specified locations. Many services, however, including inpatient and outpatient hospital care, are paid under different prospective payment systems (PPSs). In general, the program provides for annual updates to these payment amounts. The program also has rules regarding the amount of cost sharing, if any, which beneficiaries can be billed in excess of Medicare's recognized payment levels. Unlike other services, Medicare's outpatient prescription drug benefit can be obtained only through private plans. Further, while all plans have to meet certain minimum requirements, there are significant differences among them in terms of benefit design, formulary drugs, and cost-sharing amounts.

Medicare payment policies and potential changes to these policies are of continuing interest to Congress. The Medicare program has been a major focus of deficit reduction legislation since 1980. With certain exceptions, reductions in program spending have been achieved largely through regulating payments to providers, primarily hospitals and physicians. The Balanced Budget Act of 1997 (P.L. 105-33, BBA 97) modified some existing payment policies, including changing underlying payment methodologies and updates to payment amounts. Subsequent legislation increased Medicare funding to mitigate the financial impact of some BBA 97 provisions. MMA, too, modified payment methods and established payment increases for some providers. Most recently, the Tax Relief and Health Care Act of 2006 (P.L. 109-432) and the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173, or MMSEA) have affected Medicare's payments.

This report provides an overview of Medicare payment rules by type of service, outlines current payment policies, and summarizes the basic rules for program updates. The report also includes the most recent update for each type of service. At the end is a listing of CRS reports that provide more in-depth discussions of provider payment issues, followed by a list of staff contacts by Medicare topic. This report will be updated annually.

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# Medicare Payment Policies

## Introduction

Medicare is the nation's health insurance program for the aged, disabled, and persons with End Stage Renal Disease (ESRD). Part A of the program, the Hospital Insurance program, covers hospital services, up to 100 days of post-hospital skilled nursing facility services, post-institutional home health visits, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of medical services including physician services, laboratory services, durable medical equipment, and outpatient hospital services. Part B also covers some home health visits. Part C provides managed care options for beneficiaries who are enrolled in both Parts A and B. Part D provides outpatient prescription drug coverage.

## Medicare Payment Principles

In general, the total payment received by a provider for covered services provided to a Medicare beneficiary is composed of two parts: a program payment amount from Medicare plus any beneficiary cost-sharing amount that is required.[1] (The required beneficiary out-of-pocket payment may be paid by other insurance if any.) Medicare has established specific rules governing its program payments for all covered services as well as beneficiary cost sharing as described below.

### Medicare Payment Rules

Medicare has established specific rules governing payment for covered services under Parts A, B, and C.[2] For example, the program pays for most acute inpatient and outpatient hospital services, skilled nursing facility services, and home health care under a prospective payment system (PPS) established for the particular service; under PPS, a predetermined rate is paid for each unit of service such as a hospital

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[1] Not all services require cost sharing from a beneficiary. For instance, clinical laboratory services and home health services under Parts A and B of Medicare do not require payments from a beneficiary or a beneficiary's insurance, such as Medicare supplemental insurance (Medigap), Medicaid, or employer-sponsored retiree health insurance. Cost-sharing requirements under Part C plans may differ from those under Parts A and B for the same service.

[2] Outpatient prescription drugs covered under Part D are not subject to Medicare payment rules. Prices are determined through negotiation between prescription drug plans (PDPs), or Medicare Advantage prescription drug (MA-PD) plans, and drug manufacturers. The Secretary of Health and Human Services is statutorily prohibited from intervening in Part D drug price negotiations.

discharge or payment classification group. Payments for physician services, clinical laboratory services, and certain durable medical equipment are made on the basis of fee schedules.[3] Certain other services are paid on the basis of reasonable costs or reasonable charges. In general, the program provides for annual updates of the payment amounts to reflect inflation and other factors. In some cases, these updates are linked to the consumer price index for all urban consumers (CPI-U) or to a provider-specific market basket (MB) index which measures the change in the price of goods and services purchased by the provider to produce a unit of output.

## Beneficiary Out-of-Pocket Payments

There are two aspects of beneficiary payments to providers: required cost-sharing amounts (either coinsurance or deductibles) and the amounts that beneficiaries may be billed over and above Medicare's recognized payment amounts for certain services. For Part A, coinsurance and deductible amounts are established annually; these payments include deductibles and coinsurance for hospital services, coinsurance for SNFs, no cost sharing for home health services, and nominal cost sharing for hospice care.[4] For Part B, beneficiaries are generally responsible for premiums, which are income-adjusted starting in 2007, a $135 deductible in 2008 (updated annually by the increase in the Part B premium), and a coinsurance payment of 20% of the established Medicare payment amounts. For Part C, cost sharing is determined by the private health care plans. Through 2005, the total of premiums[5] for *basic* Medicare benefits and cost sharing (deductibles, coinsurance, and co-payments) charged to a Part C enrollee could not exceed actuarially determined levels of cost sharing for those same benefits under original Medicare. This meant that plans could not charge a premium for Medicare-covered benefits without reducing cost-sharing amounts. Beginning in 2006, the constraint on a plan's ability to charge a premium for *basic* Medicare benefits was lifted. The bidding mechanism established by the MMA allows plans to charge a premium to cover *basic* Medicare

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[3] The MMA required the Secretary to establish and implement a competitive bidding program for durable medical equipment. The program would pay for certain durable medical equipment, prosthetics and orthotics based on the bids of qualified suppliers in designated areas. The program was to be phased in beginning in 2007. The proposed rule for the program was published in the *Federal Register* on May 1, 2006. Two final rules were published in the *Federal Register* on August 18, 2006, and April 10, 2007. The first round of bidding closed on September 25, 2007. CMS estimates the program will begin in these first 10 areas on July 1, 2008.

[4] In 2008, for each spell of illness, a beneficiary deductible is $1,024 to cover day 1 through 60 in a hospital. The daily coinsurance charge is $256 for each day from 61 through 90. After 90 days in the hospital, a beneficiary may draw down 60 lifetime reserve days with a daily coinsurance of $512 in 2007.

[5] Through 2005, managed care plans had the option to charge a premium for basic part A and B Medicare benefits only if the value of cost sharing for basic benefits was reduced by the same amount. If a plan chose to offer supplemental benefits not covered under original Medicare, the plan could charge a supplemental premium equal to the actuarial value of supplemental benefits; the value of the supplemental premium was not constrained by cost-sharing levels for basic Medicare benefits. All beneficiaries in Part C and original Medicare are required to pay a Part B premium, unless the Part C plan pays-down the value of the Part B premium as part of a supplemental benefit.

benefits if the costs to the plan exceed the maximum amount CMS is willing to pay for Medicare-covered benefits. The MMA eliminated the explicit inverse relationship between cost sharing for *basic* Medicare benefits and a premium for *basic* Medicare benefits. Enrollee cost sharing under Part C is now only constrained by the actuarial value of cost sharing under original Medicare. However, also beginning in 2006, the Secretary has expanded authority to negotiate or reject a bid from a managed care organization in order to ensure that the bid reasonably reflects the plan's revenue requirements. Part D cost sharing includes a deductible, co-payments, and catastrophic limits on out-of-pocket spending.[6]

For most services, there are rules on amounts beneficiaries may be billed over and above Medicare's recognized payment amounts. Under Part A, providers agree to accept Medicare's payment as payment in full and cannot bill beneficiaries amounts in excess of the coinsurance and deductibles. Under Part B, most providers and practitioners are subject to limits on amounts they can bill beneficiaries for covered services. For example, physicians and some other practitioners may choose whether or not to accept **assignment** on a claim. When a physician accepts assignment, Medicare pays the physician 80% of the approved fee schedule amount. The physician can only bill the beneficiary the 20% coinsurance plus any unmet deductible. When a physician agrees to accept assignment of *all* Medicare claims in a given year, the physician is referred to as a **participating physician.** Physicians who do not agree to accept assignment on all Medicare claims in a given year are referred to as **nonparticipating physicians.** Nonparticipating physicians may or may not accept assignment for a given service. If they do not, they may charge beneficiaries more than the fee schedule amount on nonassigned claims; for physicians, these **balance billing** charges are subject to certain limits.

For some providers such as nurse practitioners, physician assistants, and clinical laboratories, assignment is mandatory; these providers can only bill the beneficiary the 20% coinsurance and any unmet deductible. For other Part B services, such as durable medical equipment, assignment is optional; providers may bill beneficiaries for amounts above Medicare's recognized payment level and may do so without limit.

## Recent Congressional Actions with Respect to Program Payments

Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been a major focus of deficit reduction legislation considered by Congress in recent years. With a few exceptions, reductions in program spending have been achieved largely through reductions in payments to providers, primarily hospitals and physicians that together represent about half of total program payments. Most recently, Medicare's payments to managed care organizations were subject to congressional scrutiny. Regardless of

[6] For a description of Part D cost sharing, see CRS Report RL34280, *Medicare Part D Prescription Drug Benefit: A Primer*, by Jennifer O'Sullivan.

which provider payments may be targeted, past reductions stemmed, but did not eliminate, year-to-year payment increases or overall program growth.

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) achieved significant savings to the Medicare program by slowing the rate of growth in payments to providers and by enacting structural changes to the program. A number of health care provider groups stated that actual Medicare benefit payment reductions resulting from BBA 97 were larger than were intended, leading to facility closings and other limits on beneficiary access to care. In November 1999, Congress passed a package of funding increases to mitigate the impact of some BBA 97 provisions on providers. This measure, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), is part of a larger measure known as the Consolidated Appropriations Act for 2000 (P.L. 106-113). Further adjustments were made by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), part of the larger Consolidated Appropriations Act, 2001 (P.L. 106-554). In addition to increasing Medicare payment rates, the subsequent legislation mandated the development or refinement of PPSs for different Medicare covered services. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, or MMA) contained a major benefit expansion in adding prescription drug coverage; Congress included a number of provisions that affected payments to providers and changed administrative and contracting procedures. Further modifications were made to Medicare payments in the Deficit Reduction Act of 2005 (P.L. 109-171, DRA), the Tax Relief and Health Care Act of 2006 (P.L. 109-432, TRHCA), and the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173, MMSEA).

This report provides a guide to Medicare payment rules by type of benefit, but does not include the outpatient prescription drug benefit under Part D. This report includes a summary of current payment policies and basic rules for updating payment amounts. It also provides the most recent update information for each type of service.

# Medicare Payment Policies

# Part A

## 1. Inpatient Prospective Payment System (IPPS) for Short-term, General Hospitals

| Provider/service | General payment policy | General update policy | Most recent update |
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| Operating PPS for inpatient services provided by acute hospitals (Operating IPPS) | Medicare pays acute care hospitals using a prospectively determined payment for each discharge. A hospital's payment for its operating costs is calculated using a national standardized amount adjusted by a wage index associated with the area where the hospital is located or where it has been reclassified. Payment also depends on the relative resource use associated with the diagnosis related group (DRG) to which the patient is assigned. A new Medicare Severity DRG (MS-DRG) patient classification system is being phased in starting in FY2008. Medicare pays additional amounts for cases with extraordinary costs (outliers); indirect medical education (IME) (see below); and for hospitals serving a disproportionate share (DSH) of low-income patients (see below). IME and DSH payments are made through adjustments within IPPS so that hospitals receive more money for | IPPS payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket (MB) index. This is a fixed price index that measures the change in the price of goods and services purchased by hospitals to create one unit of output. The update for operating IPPS is established by statute. Under DRA, hospitals that do not submit required quality data in FY2007 and each subsequent year will have the applicable MB percentage reduced by two percentage points. In its FY2008 rule, CMS proposed that Medicare payments to IPPS hospitals be reduced by 1.2% in FY2008 and 1.8% in FY2009 because of anticipated increases in measured severity of illness because of coding changes or documentation improvements (coding creep) associated with the new MS-DRGs. P.L.110-90 reduced the | **For FY2007**, hospitals that submitted the required quality data receive the full MB increase of 3.4%. The national standardized amount for these hospitals is $4,874.49. Hospitals that did not submit the quality data receive a reduced update of 1.4%. The national standardized amount for these hospitals is 4,780.20. **For FY2008**, hospitals that submitted the required quality data receive the full MB increase of 3.3%. The national standardized amount for these hospitals is $4,990.60. Hospitals that did not submit the quality data receive a reduced update of 1.3%. The national standardized amount for these hospitals is $4,893.97. |

| Provider/service | General payment policy | General update policy | Most recent update |
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| | each Medicare discharge. Additional payments may be made for cases that involve qualified new technologies that have been approved for special add-on payments. Hospitals in Hawaii and Alaska receive a cost-of-living adjustment (COLA). Certain services are reimbursed outside of IPPS. | adjustment to 0.6% and 0.9%, respectively, but permits offsets to IPPS rate increases in FY2010, FY2011, and FY2012 to account for coding creep increases in FY2008 and FY2009 above these amounts. The law did not address the scheduled adjustment of an additional 1.8% in FY2010. | |
| Capital IPPS for short-term general hospitals (Capital IPPS) | Medicare's capital IPPS is structured similarly to its operating IPPS for short-term general hospitals. A hospital's capital payment is based on a prospectively determined federal payment rate, depends on the DRG to which the patient is assigned, and is adjusted by a hospital's geographic adjustment factor (which is calculated from the hospital's wage index data). Capital IPPS includes an IME and DSH adjustment (see below). Starting in FY2008, the IME adjustment will be phased out over a 3-year period. Additional payments are made for outliers (cases with significantly higher costs above a certain threshold). Certain hospitals may also qualify for additional payments under an exceptions process. A new hospital is paid 85% of its allowable Medicare inpatient hospital capital-related costs for its first two years of operation. | Updates to the capital IPPS are not established in statute. Capital rates are updated annually by the Centers for Medicare and Medicaid (CMS) according to a framework which considers changes in the prices associated with capital-related costs as measured by the capital input price index (CIPI) and other policy factors, including changes in case mix intensity, errors in previous CIPI forecasts, DRG recalibration, and DRG reclassification. Other adjustments include those that implement budget neutrality with respect to recalibration of DRGs, outlier payments, changes in the geographic adjustment factor, and exception payments. | The capital IPPS update for **FY2007** is 1.1%, all of which is attributed to the current forecast of the CIPI available when the final rule was published; other adjustments included in the capital update framework canceled each other out. After applying other adjustments, the FY2007 federal capital rate was $427.03. The rate used to pay hospitals in large urban areas was 3% higher. The capital IPS update for **FY2008** is 0.9%. Most of this increase is caused by the current forecast of the CIPI available when the final rule was published In FY2008 CMS eliminated the 3% payment differential for hospitals in large urban areas. After adjustments, the FY2008 capital federal rates was $426.14 per discharge. |

| Provider/service | General payment policy | General update policy | Most recent update |
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| Disproportionate share hospital adjustment | Approximately 2,800 hospitals receive the additional payments for each Medicare discharge based on a formula which incorporates the number of patient days provided to low-income Medicare beneficiaries (those who receive Supplemental Security Income (SSI)) and Medicaid recipients. A few urban hospitals, known as "Pickle Hospitals," receive DSH payments under an alternative formula that considers the proportion of a hospital's patient care revenues that are received from state and local indigent care funds. The percentage add-on for which a hospital will qualify varies according to the hospital's bed size or urban or rural location. The DSH adjustment for most categories of hospitals is capped at 12%. Urban hospitals with more than 100 beds, rural hospitals with more than 500 beds, Medicare dependent hospitals (MDHs, see below) and rural referral centers (RRC, see below) are exempt from the 12% DSH adjustment cap. | No specific update. The amount of DSH spending in any year is open-ended and varies by number of Medicare discharges as well as the type of patient seen in any given hospital. | CBO estimates DSH spending (in both operating and capital IPPS) at $9.5 billion in FY2006 and $10.0 billion in FY2007 in its March 2007 baseline. |
| Indirect Medical Education (IME) adjustment | The indirect medical education adjustment (IME) is one of two types of payments to teaching hospitals for graduate medical education (GME) costs | The IME adjustment is not subject to an annual update. BBA 97 reduced the IME adjustment in operating IPPS from a 7.7% increase for each 10% increase in a | No specific update. The amount spent on IME depends in part on the number of Medicare discharges in teaching hospitals in any given year. CBO |

| Provider/service | General payment policy | General update policy | Most recent update |
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| | (see also direct GME below). Medicare increases both its operating and capital IPPS payments to teaching hospitals; different measures of teaching intensity are used in the operating and capital IPPS. For both IPPS payments, however, the number of medical residents who can be counted for the IME adjustment is capped, based on the number of medical residents as of December 31, 1996. As established by BBA 97, teaching hospitals also receive IME payments for their Medicare managed care discharges. | hospital's ratio of interns to beds (IRB), a measure of teaching intensity in operating IPPS; by FY2001, the IME adjustment was to be 5.5%. However, the scheduled decreases were delayed by subsequent legislation. MMA provides an increased IME adjustment to 6.0% from April 1, 2004-September 30, 2004; during FY2005 the adjustment is 5.8%; during FY2006 the adjustment is 5.55%; and during FY2007 the adjustment is 5.35%; starting FY2008 and subsequently, the adjustment returns to 5.5%. | estimates the IME payments (for both capital and operating IPPS) to be about $5.9 billion in FY2006 and $6.0 billion in FY2007 in its March 2007 baseline. |

| **Provider/service** | **General payment policy** | **General update policy** | **Most recent update** |
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| Direct graduate medical education payments | Direct GME costs are excluded from IPPS and paid outside of the DRG payment on the basis of updated hospital-specific costs per resident amount (PRA), the number of weighted full-time equivalent (FTE) residents, and Medicare's share of total patient days in the hospital (including those days attributed to Medicare manged care enrollees). There is a hospital-specific cap on the number of residents in the hospital for direct GME payments. Also, the hospital's FTE count is based on a three-year rolling average; a specific resident may count as half of a FTE, depending on the number of years spent as a resident and the length of the initial training associated with the specialty. Certain combined primary care residency programs receive special recognition in this count. Depending upon the circumstances, direct GME payments can be made to nonhospital providers. | In general, direct GME payments are updated by the increase in the consumer price index for all urban consumers (CPI-U). As established by BBRA and subsequently amended, however, the update amount that any hospital receives depends upon the relationship of its PRA to the national average PRA. Hospitals with PRAs below the floor (85% of the locality-adjusted, updated, and weighted national PRA) are raised to the floor amount. Teaching hospitals with PRAs above the ceiling amount (140% of the national average, adjusted for geographic location) will receive a lower update than other hospitals (CPI-U minus two percentage points) for FY2003-FY2013. Hospitals that have PRAs between the floor and ceiling receive the CPI-U. | Hospitals below 140% of the national average from FY2004-FY2013 receive an update of CPI-U. Hospitals above 140% of the national average for that time period will receive no update. CBO estimates direct GME payments of $2.3 billion in FY2006 and $2.4 billion in FY2006 in its March 2007 baseline. |

## 2. Hospitals Receiving Special Consideration Under Medicare's IPPS

| Provider/service | General payment policy | General update policy | Most recent update |
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| Sole Community Hospitals (SCHs) — facilities located in geographically isolated areas and deemed to be the sole provider of inpatient acute care hospital services in a geographic area based on distance, travel time, severe weather conditions, and/or market share as established by specific criteria set forth in regulation (42 CFR 412.92). | An SCH receives the higher of the following payment rates as the basis of reimbursement: the current IPPS base payment rate, or its hospital-specific per-discharge costs from either FY1982, 1987, or 1996, updated to the current year. An SCH may receive additional payments if the hospital experiences a decrease of more than 5% in its total inpatient cases due to circumstances beyond its control. An SCH receives special consideration for reclassification into a different area. Starting for services on January 1, 2006, CMS increased outpatient prospective payment system (OPPS) payments to rural SCHs by an additional 7.1%. | Target amounts for SCHs are updated by an "applicable percentage increase" which is specified by statute and is often comparable to the IPPS update. | **For FY2007,** hospitals that submitted the required quality data receive the full MB increase of 3.4%. Hospitals that did not submit the quality data receive a reduced update of 1.4%. **For FY2008**, hospitals that submitted the required quality data receive the full MB increase of 3.5%. Hospitals that did not submit the quality data receive a reduced update of 1.5%. |
| Medicare dependent hospitals (MDHs) — small rural hospitals with a high proportion of patients who are Medicare beneficiaries (have at least 60% of acute inpatient days or discharges attributable to Medicare in | BBA 97 reinstated and extended the MDH classification, starting on October 1, 1997, and extending to October 1, 2001. The sunset date for the MDH classification was subsequently extended to September 30, 2011 by DRA. Until October 1, 2006, an MDH was paid the federal rate plus 50% of the amount that the rate is exceeded by the hospital's | Target amounts for MDHs are updated by an "applicable percentage increase" which is specified by statute and is often comparable to the IPPS update. CMS estimated that the DRA changes increased Medicare payments to MDHs by 14% in FY2007. | For FY1996 and thereafter, the update for MDHs is the same as for all IPPS hospitals. These updates are also used to increase the hospital-specific rate applicable to an MDH. **For FY2007,** hospitals that submitted the required quality data receive the full MB increase of 3.4%. Hospitals that did not submit the quality data receive a reduced update |

| **Provider/service** | **General payment policy** | **General update policy** | **Most recent update** |
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| FY1987 or in two of the three most recently audited cost reporting periods). As specified in regulation (42 CFR 412.108), they cannot be an SCH and must have 100 or fewer beds. | target amount based on either its updated FY1982 or FY1987 cost per discharge. DRA provided that an MDH would be able to elect payments based on using a percentage of its FY2002 hospital-specific cost starting October 1, 2006. An MDH's payments would be based on 75% of the adjusted hospital-specific cost starting for discharges on October 1, 2006. DRA also excluded MDHs from the 12% DSH adjustment cap for discharges starting October 1, 2006. An MDH may receive additional payments if its inpatient cases decline more than 5% due to circumstances beyond its control. | | of 1.4%. **For FY2008**, hospitals that submitted the required quality data receive the full MB increase of 3.5%. Hospitals that did not submit the quality data receive a reduced update of 1.5%. |
| Rural Referral Centers (RRCs) — relatively large hospitals, generally in rural areas, that provide a broad array of services and treat patients from a wide geographic area as established by specific criteria set forth in regulation. (42 CFR 412.96). | RRCs payments are based on the IPPS for short-term general hospitals. RRCs are exempt from the 12% DSH adjustment cap. Also, RRCs receive preferential consideration for reclassification to a different area. | RRCs receive the operating and capital IPPS updates specified for short-term general hospitals. | See updates specified for operating and capital IPPS for short-term general hospitals. |

## 3. IPPS-Exempt Hospitals and Distinct Part Units

| Provider/service | General payment policy | General update policy | Most recent update |
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| Inpatient Rehabilitation Facilities (IRFs) — freestanding hospitals and hospital-based distinct part units that treat a percentage of patients with a defined set of conditions and meet certain established conditions of participation. As established by MMSEA, starting July 1, 2007, the IRF compliance threshold (which determines whether a facility is an IRF or an acute care hospital) is set at 60%; comorbidities are included as qualifying conditions. To be paid as an IRF, an entity must have 60% of its inpatients with one of 13 conditions including stroke, spinal cord injury, brain injury, neurological disorder, burns, and | As of January 1, 2002, Medicare's payments to a rehabilitation facility are based on a fully implemented IRF-PPS and 100% of the federal rate which is a fixed amount per discharge. This PPS encompasses both capital and operating payments to IRFs, but does not cover the costs of approved educational programs, bad debt expenses, or blood clotting factors, which are paid for separately. The IRF-PPS payment for any Medicare discharge will vary depending on the patient's impairment level, functional status, comorbidity conditions, and age. These factors determine which of the 87 Case Mix Groups (CMGs) is assigned to the inpatient stay. Within each of these CMGs, patients are further assigned to one of four tiers based on any comorbidities they may have. Five other CMGs are used for patients discharged before the fourth day (short stay outliers) and for those who die in the facility. Generally, IRF payments are reduced or increased for certain case level adjustments, such as early transfers, short-stay outliers, patients who die | Starting in FY2006, the IRF-PPS update is based on the MB reflecting 2002 cost structures from rehabilitation, long-term care, and psychiatric hospitals (RLP-MB). The RLP-MB includes an update estimate for capital as well as operating costs. MMSEA establishes the IRF update factor at 0% in FY2008 and FY2009, starting for discharges on April 1, 2008. | The update for **FY2007** is 3.3%. In 2007, IRF-IPPS included a reduction of 2.6% to account for coding changes, for a net increase of 0.6%. After budget neutrality adjustments, the FY2007 IRF federal base rate is $12,981. In the FY2008 IRF rule CMS established the update for **FY2008** as 3.2% and the base federal base rate as $13,451. However, in December 2007, MMSEA established the IRF update factor at 0% in FY2008 and FY2009 starting for discharges on April 1, 2008. |

| Provider/service | General payment policy | General update policy | Most recent update |
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| certain arthritis related conditions. | before transfer, and high cost outliers. Payments also depend upon facility-specific adjustments to accommodate variations in area wages, percentage of low income patients (LIP) served by the hospital (a DSH adjustment), and rural location (rural IRFs receive increased payments, about 19% more than urban IRFs.) Starting in FY2006, an IME adjustment is included; IRFs in Alaska and Hawaii do not receive a COLA adjustment. The IRF-PPS is not required to be budget neutral; total payments can exceed the amount that would have been paid if this PPS had not been implemented. | | |
| Long-Term Care Hospitals and satellites or onsite providers (LTCHs) — acute general hospitals that are excluded from IPPS with a Medicare inpatient average length of stay (ALOS) greater than 25 days. | Effective October 1, 2002, LTCHs are paid on a discharge basis under a DRG-based PPS, subject to a five-year transition period. The LTCH-PPS encompasses payments for both operating and capital-related costs of inpatient care but does not cover the costs of approved educational programs, bad debt expenses, or blood clotting factors which are paid for separately. The LTCH-PPS payment for any Medicare discharge will vary depending on the patient's assignment into a | The LTCH update is not specified in statue. CMS has established a policy to update the LTCH rates based on the most recent estimate of the rehabilitation, psychiatric, and long-term care (RPL) market basket adjusted to account for improved coding practices. CMS changed the effective date of the annual update from October 1 to July 1 of each year, starting July 2003. MMSEA established a three-year moratorium period during which the Secretary will not be able to apply certain payment | There was no increase to the LTCH base payment rates for **RY2006** or **RY2007**. The LTCH federal payment rate remains $38,086. In RY2008, CMS proposed a 0.71% update which reflects a 3.2% MB increase and a 2.49% correction for coding improvements. The **RY2008** federal payment rate was $38,356.45. Under MMSEA, the base rate for LTCH's RY2008 was established as the same as that in RY2007. The provision would apply to discharges starting April 1, 2008. |

| Provider/service | General payment policy | General update policy | Most recent update |
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| | Medicare severity- LTC-DRGs, which are based on reweighted IPPS MS-DRGs. Payments for specific patients may be increased or reduced because of case-level adjustments, such as short stay cases, interrupted stay cases, readmitted cases from co-located providers and high costs outliers. Payments also depend upon facility-specific adjustments such as variations in area wages and include a COLA for hospitals in Alaska and Hawaii. No adjustments are made for the percentage of low income patients served by the hospital (DSH), rural location, or IME. The LTCH-PPS is required to be budget neutral; total payments must equal the amount that would have been paid if PPS had not been implemented. | policies, including payments for short stay outliers or the one-time adjustment to LTCH prospective payments to ensure budget neutrality. | |
| Psychiatric hospitals and distinct part units — include those primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of people with mental illness. | Starting January 1, 2005, Medicare pays for services provided in inpatient psychiatric facilities (IPF) using a per-diem based PPS. Established with a three-year transition period, the IPF-PPS incorporates patient-level adjustments for specified DRGs, selected comorbidies, and in certain cases, age of the patient. Facility-level adjustments for relative wages, teaching status and | The IPF update is not specified in statue. CMS has established a policy to update the per diem rates based on the most recent estimate of the rehabilitation, psychiatric, and long-term care market basket (RPL-MB) The IPF-PPS payments must be projected to equal the amount of total payments that would have been made under the prior payment system. The initial calculation of the per | The update for **RY2007** of 4.3% was applied to a corrected base per diem amount that was then increased by a wage index budget neutrality factor. The Federal per diem base rate for is $595. The update for **RY2008** is 3.2%. The federal base payment is $615 per day. |

| Provider/service | General payment policy | General update policy | Most recent update |
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| | rural location are also included. IPFs in Hawaii and Alaska will receive a COLA adjustment. Medicare per diem payments are higher in the earlier days of the psychiatric stay. Also, the per diem payment for the first day of each stay is 12% higher in IPFs with qualifying (full-service) emergency departments than in other IPFs. An outlier policy for high-cost cases is included. Patients who are discharged from an IPF and return within three days are considered readmissions of the same case. IPFs also receive an additional payment for each eletroconvulsive therapy treatment furnished to a patient. Finally, under the stop-loss provision, during the three-year transition period ending in 2008, an IPF is guaranteed at least 70% of the aggregate payments that would made under the prior payment system. | diem payment included a 16.33% reduction to account for standardization to projected TEFRA (the prior payment system) payments, a 2% reduction to account for outlier payments, a 0.39% reduction to account for the stop-loss provision and a 2.66% reduction to account for a behavioral offset (to reflect changing utilization under the new payment system). | |
| Children's and cancer hospitals:<br><br>***Children's hospitals*** are those engaged in furnishing services to inpatients who are predominantly individuals | Children's and cancer hospitals are paid on a reasonable cost basis, subject to TEFRA payment limitations and incentives. Each provider's reimbursement is subject to a ceiling or target amount that serves as an upper limit on operating costs. Depending upon the relationship of the hospital's | An update factor for reimbursement of operating costs is established by statute. Starting in FY2006, IPPS operating MB increase is used to update the target amounts. The amount of increase received by any specific hospital will depend upon the relationship of the hospital's costs to its target amount. | The update for **FY2007** is 3.4%. The update for **FY2008** is 3.3%. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| under the age of 18. ***Cancer hospitals*** are generally recognized by the National Cancer Institute as either a comprehensive or clinical cancer research center; are primarily organized for the treatment of and research on cancer (not as a subunit of another entity); and have at least 50% of their discharges with a diagnosis of neoplastic disease. See 42 CFR 412.23(f). | actual costs to its target amount, these hospitals may receive relief or bonus payments as well as additional bonus payments for continuous improvement (i.e., facilities whose costs have been consistently less than their limits may receive additional money). Newly established hospitals receive special treatment. Providers that can demonstrate that there has been a significant change in services and/or patients may receive exceptions payments. The capital costs for these hospitals are reimbursed on a reasonable cost basis. | There is no specific update for capital costs. | |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Critical Access Hospitals (CAHs) are limited-service facilities that are located more than 35 miles from another hospital (15 miles in certain circumstances) or designated by the state as a necessary provider of health care; offer 24-hour emergency care; have no more than 25 acute care inpatient beds and have a 96-hour average length of stay. Beds in distinct-part skilled nursing facility, psychiatric or rehabilitation units operated by a CAH do not count toward the bed limit. | Medicare pays CAHs on the basis of the reasonable costs of the facility for inpatient and outpatient services. CAHs may elect either a cost-based hospital outpatient service payment or an all-inclusive rate which is equal to a reasonable cost payment for facility services plus 115% of the fee schedule payment for professional services. Ambulance services that are owned and operated by CAHs are reimbursed on a reasonable cost basis if these ambulance services are 35 miles from another ambulance system. MMA provided that inpatient, outpatient, and swing bed services provided by CAHs will be paid at 101% of reasonable costs for cost reporting periods beginning January 1, 2004. | No specific update policy. | No specific update policy. |

## 4. Skilled Nursing Facility (SNF) Care

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| SNF care | SNFs are paid through a prospective payment system (PPS) which is composed of a daily (“per-diem”) urban or rural base payment amount that is then adjusted for case mix and area wages.<br><br>The federal per diem payment is intended to cover all the services provided to the beneficiary that day, including room and board, nursing, therapy, and prescription drugs. Some care costs are excluded from PPS and paid separately such as physician visits, dialysis and certain high cost prosthetics and orthotics.<br><br>The case-mix adjustment to the base per diem rate adjusts payments for the treatment and care needs of Medicare beneficiaries and categorizes individuals into groups called resource utilization groups (RUGs). The RUGs system uses patient assessments to assign a beneficiary to one of 53 categories and to determine the payment for the beneficiary’s care. Patient assessments are done at various times during a | The urban and rural federal per diem payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the SNF market basket (MB) index. This index measures changes in the costs of goods and services purchased by SNFs. Each year, the update of the payment rate also includes, as appropriate, an adjustment to account for the MB forecast error for previous years. Before FY2008, when the difference between the estimated MB update and the actual increase was greater than 0.25 percentage points, payments to SNFs would be updated to account for this forecast error. When the difference was less than 0.25 percentage points, no adjustments were made. The threshold for adjusting a forecast error was raised, by regulation, to 0.5 percentage points for FY2008 and subsequent years. | **For FY2007**, SNFs received the full MB increase of 3.1%. **For FY2008**, SNFs will receive the full MB increase of 3.3%. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | patient's stay and the RUG category in which a beneficiary is placed can change with changes in the beneficiary's condition. In addition to being adjusted for case-mix, the federal payment is also adjusted to account for variations in area wages, using the hospital wage index. Starting on October 1, 2004, MMA increased payments for AIDS patients in SNFs by 128%. Unlike other PPSs, the SNF PPS statute does not provide for an adjustment for extraordinarily costly cases (an "outlier" adjustment). DRA reduced payments to SNFs for beneficiary bad debts to 70% for non-duals (individuals who are not enrolled in both Medicare and Medicaid). Bad debt payments for dual eligibles (individuals enrolled in both Medicare and Medicaid) remain at 100%. | | |

## 5. Hospice Care

| Provider/Service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Hospice care | Payments for hospice care contain three separate components that are adjusted annually. These components are the payment rates, the hospice wage index, and the cap amount.<br><br>**Payment rates** are based on one of four prospectively determined rates which correspond to four different levels of care (i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care) for each day a beneficiary is under the care of the hospice.<br><br>The **hospice wage index** is used to adjust payment rates to reflect local differences in area wage levels. This index is established using the most current hospital wage data available.<br><br>Total payments to a hospice are subject to an aggregate **cap** that is determined by multiplying the cap amount for a given year by the number of Medicare beneficiaries who receive hospice services during the year. Medicare payments to hospices that exceed this amount must be returned to the Medicare program. Limited cost sharing applies to outpatient drugs and respite care. | Each of the three components are updated annually. The prospective **payment rates** are updated by the increase in the hospice market basket (MB). Since FY2003 updates have been at the full hospital MB percentage increase.<br><br>The **hospice wage index** is updated to reflect updates in the hospital wage index and any changes to the definition of Metropolitan Statistical Areas (MSAs).<br><br>The hospice **cap** amount is increased or decreased annually by the same percentage as the medical care expenditure category of the CPI-U. | The **FY2007 payment rates** were updated by the MB of 3.4%. The national hospice payment rates for care furnished during **FY2007** were as follows: routine home care — $130.79 per day; continuous home care — $763.36; inpatient respite care — $135.30 per day; general inpatient care — $581.82 per day.<br><br>The **FY2008 payment rates** are updated by the MB of 3.3%. The national hospice payment rates for care furnished during **FY2008** are as follows: routine home care — $135.11 per day; continuous home care — $788.55; inpatient respite care — $139.76 per day; and general inpatient care — $601.02 per day.<br><br>The latest hospice **cap** amount for the cap year ending October 31, 2007, is an aggregated $21,410.04 per beneficiary. For the year, November 1, 2005 - October 31, 2006 it was $20,585.39. |

# Part B

## 1. Physicians

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Physicians | Payments for physicians services are made on the basis of a fee schedule. The fee schedule assigns relative values to services. These relative values reflect physician work (based on time, skill, and intensity involved), practice expenses, and malpractice expenses. The relative values are adjusted for geographic variations in the costs of practicing medicine. These geographically adjusted relative values are converted into a dollar payment amount by a conversion factor. Assistants-at-surgery services are paid 16% of the fee schedule amount.<br><br>Anesthesia services are paid under a separate fee schedule (based on base and time units) with a separate conversion factor.<br><br>Payments equal 80% of the fee schedule amount; patients are liable for the remaining 20%. (Payments for certain mental health services equal 50% of the | The conversion factor is updated each year by a formula specified in law. The update percentage equals the Medicare Economic Index (MEI, which measures inflation) subject to an adjustment to match spending under the cumulative sustainable growth rate (SGR) system. (The SGR is linked, in part, to changes in the gross domestic product.) The adjustment sets the conversion factor so that projected spending for the year will equal allowed spending by the end of the year. In no case can the conversion factor update be more than three percentage points above nor more than seven percentage points below the MEI. Application of the SGR system led to a 5.4% reduction in the conversion factor in 2002. Additional reductions were slated to take effect in subsequent years. However, P.L. 108-7 allowed for revisions in previous estimates used for the SGR calculation, thereby permitting an update of 1.6% effective March 1, | The conversion factor for the **first six months of 2008** is $38.087, a 0.5% increase over the 2007 amount. The anesthesia conversion factor for the **first six months of 2008** is $17.8482. Absent additional Congressional action, the conversion factors will fall to a level approximately 10% below the 2007 amounts beginning July 1, 2008.<br><br>Several additional changes were incorporated in the both the 2007 and 2008 fee schedules (including modifying the relative values for a number of services and the continuing phase-in of a revision in the way practice expenses are calculated). As a result, in the first six months of 2008, payments for some services will decrease, while payments for other services will increase from the 2007 amount. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | fee schedule amounts; patients are liable for the other 50%). Assignment is optional; balance billing limits apply on non-assigned claims. | 2003. MMA provided that the update to the conversion factor for 2004 and 2005 could not be less than 1.5%. DRA froze the 2006 rate at the 2005 level, TRHCA froze the 2007 rate at the 2006 level; and MMSEA provided that the level for the first six months of 2008 is increased by 0.5%. | |

## 2. Nonphysician Practitioners

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| (a) Physician Assistants | Separate payments are made for physician assistant (PA) services, when provided under the supervision of a physician, but only if no facility or other provider charge is paid. Payment is made to the employer (such as a physician). The PA may be in an independent contractor relationship with the employer.<br><br>The recognized payment amount equals 85% of the physician fee schedule amount (or, for assistant-at-surgery services, 85% of the amount that would be paid to a physician serving as an assistant-at-surgery). Medicare payments | See physician fee schedule. | See physician fee schedule. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory for PA services. | | |
| (b) Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) | Separate payments are made for NP or CNS services, provided in collaboration with a physician, but only if no other facility or other provider charge is paid.<br><br>The recognized payment amount equals 85% of the physician fee schedule amount (or, for assistant-at-surgery services, 85% of the amount that would be paid to a physician serving as an assistant-at-surgery). Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory. | See physician fee schedule. | See physician fee schedule. |
| (c) Nurse midwives | The recognized payment amount for certified nurse midwife services equals 65% of the physician fee schedule amount. Nurse midwives can be paid directly. Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory. | See physician fee schedule. | See physician fee schedule. |
| (d) Certified Registered Nurse Anesthetists (CRNAs) | CRNAs are paid under the same fee schedule used for anesthesiologists. Payments furnished by an anesthesia care | See physician fee schedule. | See physician fee schedule. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | team composed of an anesthesiologist and a CRNA are capped at 100% of the amount that would be paid if the anesthesiologist was practicing alone. The payments are evenly split between each practitioner. CRNAs can be paid directly. Assignment is mandatory for services provided by CRNAs. Regular Part B cost sharing applies. | | |
| (e) Clinical Psychologists and Clinical Social Workers | The recognized payment amount for services provided by a clinical social worker is equal to 75% of the physician fee schedule amount.<br><br>Services in connection with the treatment of mental, psychoneurotic, and personality disorders of a patient who is not a hospital inpatient are subject to the mental health services limitation. In these cases Medicare pays 50% of incurred expenses and the patient is liable for the remaining 50%. Otherwise, regular Part B cost sharing applies. Assignment is mandatory for services provided by clinical psychologists and clinical social workers. | See physician fee schedule. | See physician fee schedule. |
| (f) Outpatient physical or occupational therapy services | Payments are made under the physician fee schedule. | Updates in fee schedule payments are dependent on the update applicable under the physician fee schedule. The $1,500 | See physician fee schedule. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | In 1999, an annual $1,500 per beneficiary limit applied to all outpatient physical therapy services (including speech-language pathology services), except for those furnished by a hospital outpatient department. A separate $1,500 limit applied to all outpatient occupational therapy services except for those furnished by hospital outpatient departments. Therapy services furnished as incident to physicians professional services were included in these limits.<br><br>The $1,500 limits were to apply each year. However, no limits applied from 2000-2005, except for a brief period in 2003. The limits were restored in 2006; however, an exceptions process applies in 2006, 2007, and the first six months of 2008.<br><br>Regular Part B cost sharing applies. Assignment is optional for services provided by therapists in independent practice; balance billing limits apply for non-assigned claims. Assignment is mandatory for other therapy services. | limits were to be increased by the increase in the MEI beginning in 2002; however, application of the limits was suspended until September 1, 2003. At that time the limits were $1,590. MMA suspended the application of the limits beginning December 8, 2003-December 31, 2005. The limits were restored January 1, 2006. The 2006 limits were $1,740; the 2007 limits were $1,780, and the 2008 limits are $1,810. DRA required the Secretary to establish an exceptions process for 2006 for certain medically necessary services. TRHCA extended the exceptions process through 2007; MMSEA extended the process an additional six months. | |

## 3. Clinical Diagnostic Laboratory Services

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Clinical diagnostic laboratory services | Clinical lab services are paid on the basis of area-wide fee schedules. The fee schedule amounts are periodically updated. There is a ceiling on payment amounts equal to 74% of the median of all fee schedules for the test. Assignment is mandatory. No cost sharing is imposed. | Generally, the Secretary of HHS is required to adjust the payment amounts annually by the percentage change in the CPI, together with such other adjustments as the Secretary deems appropriate. Updates were eliminated for 1998 through 2002. MMA eliminated updates for 2004-2008. | The fee schedules were updated by 1.1% in **2003**. No update was made for **2004, 2005, 2006, 2007, or 2008**. |

## 4. Preventive Services

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Pap smears; pelvic exams | Medicare covers screening pap smears and screening pelvic exams once every two years; annual coverage is authorized for women at high risk. Payment is based on the clinical diagnostic laboratory fee schedule. Assignment is mandatory. No cost sharing is imposed. | See clinical laboratory fee schedule. A national minimum payment amount applies for pap smears. | See clinical laboratory fee schedule. Minimum payment for pap smears in **2008** is $14.76 (the same as 2007). |

| **Provider/service** | **General payment policy** | **General update policy** | **Most recent update** |
|---|---|---|---|
| Screening mammograms | Coverage is authorized for an annual screening mammogram. Payment is made under the physician fee schedule. The deductible is waived; regular Part B coinsurance applies. Assignment is optional. Balance billing limits apply on non-assigned claims. | See physician fee schedule. | See physician fee schedule. |
| Colorectal screening | Coverage is provided for the following procedures for the early detection of colon cancer: (1) screening fecal occult blood tests (for persons over 50, no more than annually); (2) screening flexible sigmoidoscopy (for persons over 50, no more than once every four years and 10 years after a screening colonoscopy for those not at high risk for colon cancer); (3) screening flexible colonoscopy for high-risk individuals (limited to one every two years) and for those not at high risk, every 10 years or four years after a screening sigmoidoscopy; and (4) barium enemas (as an alternative to either a screening flexible sigmoidoscopy or screening colonoscopy in accordance with the same screening parameters established for those tests).<br><br>Payments are based on rates paid for the same procedure when done for a | See physician fee schedule and laboratory fee schedule. | See physician fee schedule and laboratory fee schedule. |

| **Provider/service** | **General payment policy** | **General update policy** | **Most recent update** |
|---|---|---|---|
| | diagnostic purpose. Fecal occult blood tests are paid under the laboratory fee schedule; other tests are paid under physician fee schedule. If a sigmoidoscopy or colonoscopy results in a biopsy or removal of a lesion, it would be classified and paid as the procedure with such biopsy or removal, rather than as a diagnostic test. Assignment is mandatory for fecal occult blood tests and no cost sharing applies. Assignment is optional for sigmoidoscopies and colonoscopies. DRA specified that the Part B deductible does not apply for screenings, effective January 1, 2007. Balance billing limits apply on non-assigned claims. | | |
| Prostate cancer screening | Medicare covers an annual prostate cancer screening test. Payment is made under the physician fee schedule. | See physician fee schedule. | See physician fee schedule. |
| Glaucoma screening | Medicare covers an annual glaucoma screening for persons with diabetes, persons with a family history of glaucoma, African-Americans age 50 and over, and Hispanic Americans age 65 and over. Payment is made under the physician fee schedule. | See physician fee schedule. | See physician fee schedule. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Diabetes outpatient self-management training | Medicare covers services furnished by a certified provider. Payment is made under the physician fee schedule. | See physician fee schedule. | See physician fee schedule. |
| Medical nutrition therapy services | Coverage is authorized for certain individuals with diabetes or renal disease. Payment equals 85% of the amount established under the physician fee schedule for the service if it had been furnished by a physician. | See physician fee schedule. | See physician fee schedule. |
| Bone mass measurements | Bone mass measurements are covered for certain high-risk individuals. Payments are made under the physician fee schedule. In general, services are covered if they are provided no more frequently than once every two years. | See physician fee schedule. | See physician fee schedule. |
| Ultrasound screenings for abdominal aortic aneurysms | Ultrasound screenings for abdominal aortic aneurysms are covered for individuals who: (1) receive a referral for such screening during the initial preventive services exam; (2) have not had such a screening paid for by Medicare; and (3) have a family history of abdominal aortic aneurysm or manifest certain risk factors. | See physician fee schedule. | See physician fee schedule. |

## 5. Telehealth

| Provider/Service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Telehealth services | Medicare pays for services furnished via a telecommunications system by a physician or practitioner, notwithstanding the fact that the individual providing the service is not at the same location as the beneficiary. Payment is equal to the amount that would be paid under the physician fee schedule if the service had been furnished without a telecommunications system. A facility fee is paid to the originating site (the site where the beneficiary is when the service is provided). | See physician fee schedule. The facility fee equals the amount established for the preceding year, increased by the percentage increase in the MEI. | See physician fee schedule. The **2008** facility fee is $23.35 (compared to $22.94 in 2007). |

## 6. Durable Medical Equipment (DME)

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Durable Medical Equipment (DME) | Except in designated Competitive Bidding Areas, DME is paid on the basis of a fee schedule. Items are classified into five groups for purposes of determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment | In general, fee schedule amounts are updated annually by the CPI-U.<br><br>Updates were eliminated for 1998-2000; payments were increased by the CPI-U for 2001; and payments were frozen for 2002. MMA eliminated the updates for | The update for **2003** was 1.1%. As required by MMA, there were no updates for **2004, 2005, 2006, 2007, and 2008**. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | (defined as items costing less than $150 or which are purchased at least 75% of the times); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, fee schedule rates are established locally and are subject to national limits. The national limits have floors and ceilings. The floor is equal to 85% of the weighted average of all local payment amounts and the ceiling is equal to 100% of the weighted average of all local payment amounts. Assignment is optional. Balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies. MMA requires that, beginning in 2007, the Secretary begin a program of competitive acquisition for DME. Competitive acquisition is to begin in 10 metropolitan statistical areas (MSAs) in 2007, expand to 80 MSAs in 2008, and expand to additional areas in 2009. The Secretary is authorized to phase-in competitive acquisition among the highest cost and highest volume items and services or those items and services that the | 2004-2008. | |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | Secretary determines have the largest savings potential. The first round of bids were submitted on September 25, 2007. CMS estimates the program will begin on July 1, 2008. | | |

## 7. Prosthetics and Orthotics

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Prosthetics and orthotics | Prosthetics and orthotics are paid on the basis of a fee schedule. These rates are established regionally and are subject to national limits which have floors and ceilings. The floor is equal to 90% of the weighted average of all regional payment amounts and the ceiling is equal to 120% of the weighted average of all regional payment amounts. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies. | Fee schedule amounts are updated annually by the CPI-U. MMA eliminated the updates for 2004-2006. | The update for **2003** was 1.1%. As required by MMA, there were no updates for **2004, 2005** and **2006.** The update for 2007 was 4.3%. The update for 2008 is 2.7% |

## 8. Surgical Dressings

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Surgical Dressings | Surgical dressings are paid on the basis of a fee schedule. Payment levels are computed using the same methodology as the durable medical equipment fee schedule (see above). Assignment is optional; balance billing limits do not apply to non-assigned claims. Regular Part B cost sharing applies. | See durable medical equipment fee schedule. | The update for **2003** was 1.1%. There was no update for **2004**, **2005, 2006, 2007**, and **2008**. |

## 9. Parenteral and Enteral Nutrition (PEN)

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Parenteral and Enteral Nutrition (PEN) | Parenteral and enteral nutrients, equipment, and supplies are paid on the basis of the PEN fee schedule. Prior to 2002, PEN was paid on a reasonable charge basis (see below under Miscellaneous Items and Services). The fee schedule amounts are based on payment amounts made on a national basis to PEN suppliers under the reasonable charge system. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies. | Fee schedule amounts are updated annually by the CPI-U. | The **2008** rate increased by the CPI-U, is 2.7% (compared to 4.3% in 2007). |

## 10. Miscellaneous Items and Services

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Miscellaneous services | Miscellaneous items and services here refers to those services still paid on a reasonable charge basis. Included are such items as splints, casts, home dialysis supplies and equipment, therapeutic shoes, certain intraocular lenses, blood products, and transfusion medicine. These charges may not exceed any of the following fee screens: (1) the supplier's customary charge for the item, (2) the prevailing charge for the item in the locality, (3) the charges made to the carrier's policyholders or subscribers for comparable items, (4) the inflation-indexed charge. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies. | Payments for reasonable charge items are calculated annually. Carriers determine a supplier's customary charge level. Prevailing charges may not be higher than 75% of the customary charges made for similar items and services in the locality during the 12-month period of July 1- June 30 of the previous calendar year. The inflation-indexed charge is updated by the CPI-U. | The update to the inflation-indexed charge for **2007** is 4.3%. The update to the inflation-indexed charge for **2008** is 2.7%. |

## 11. Ambulatory Surgical Centers (ASCs)

| Provider/service | General Payment policy | General update policy | Most recent update |
|---|---|---|---|
| Ambulatory Surgical Centers (ASCs) | Starting January 1, 2008, Medicare will pay for surgery-related facility services provided in an ASC using a payment system based on the hospital outpatient prospective payment system (OPPS). The new payment system will be implemented over a four-year transition period. The ASC payment system uses the same payment groups (APCs) as the OPPS. Many of the ASC relative weights procedures will be the same as in OPPS. Certain services will be eligible for separate payments. The relative weights will be multiplied by a conversion factor (average payment amount) to get a payment for a specific procedure. The ASC conversion factor is based on a percentage of the OPPS conversion factor set to ensure budget neutrality between the old ASC payment system and the new one. CMS uses different methods to set payments for new office-based procedures, separately payable radiology services, separately payable drugs and device intensive services. | MMA eliminated the payment update for FY2005 under the prior payment system, changed the update cycle to a calendar year from a fiscal year, and eliminated the updates for calendar years 2006-2009. MMA also established that a revised payment system for surgical services furnished in an ASC will be implemented on or after January 1, 2006, and not later than January 1, 2008. Total payments under the new system should be equal to the total projected payments under the old system. As established by the TRHCA, starting in CY2009, the annual increase for ASCs that do not submit required quality data may be the required update minus -2 percentage points. The reduction for not submitting quality data would apply for the applicable year only, and not for subsequent years. | Beginning in CY2010, the ASC conversion factor will be updated annually using the consumer price index for all urban consumers (CPI-U). In CY2008, the ASC conversion factor was established at 65% of the OPPS conversion factor or $41.401 |

## 12. Hospital Outpatient Services

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Hospital Outpatient Departments (HOPDs) | Under HOPD-PPS, which was implemented in August 2000, the unit of payment is the individual service or procedure as assigned to one of about 570 ambulatory payment classifications (APCs). To the extent possible, integral services and items are bundled within each APC, specified new technologies are assigned to new technology APCs until clinical and cost data is available to permit assignment into a clinical APC. Medicare's payment for HOPD services is calculated by multiplying the relative weight associated with an APC by a conversion factor. For most APC s, 60% of the conversion factor is geographically adjusted by the IPPS wage index. Except for new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. Certain APCs with significant fluctuations in their relative weights will have the calculated change dampened. The HOPD-PPS also includes budget-neutral pass-through payments for new technology and budget-neutral outlier payments. Cancer and children's hospitals have a | The conversion factor is updated on a calendar year schedule. These annual updates are based on the hospital IPPS MB. As established by TRHCA, starting in CY2009, the update for hospitals that do not submit required quality data will be the MB minus 2 percentage points. The reduction for not submitting quality data would apply for the applicable year, and would not be taken into account in subsequent years. | For **CY2007**, the IPPS MB was 3.4%. This increase was adjusted by the required wage index and pass-through budget- neutrality factors, including one to account for the rural SCH payment adjustment. The final CY2007 conversion factor was $61.468.<br>For **CY2008**, the IPPS MB was 3.3%. This increase was adjusted by the required wage index and pass-through budget-neutrality factors, including one to account for the rural SCH payment adjustment. The final CY2008 conversion factor was $63.694. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | permanent hold harmless protection from the HOPD-PPS. HOPDs in rural hospitals with 100 or fewer beds (that are not SCHs) will receive at least 95% of the payment it would have received under the prior payment system during CY2006. The percentage will be reduced to 90% during 2007 and 85% during 2008. Starting for services on January 1, 2006, rural SCHs will receive a 7.1% payment increase.<br><br>Over time, under Medicare's prior payment system, beneficiaries' share of total outpatient payments grew to 50%. HOPD-PPS slowly reduces the beneficiary's copayment for these services. Copayments will be frozen at 20% of the national median charge for the service in 1996, updated to 1999. Over time, as PPS amounts rise, the frozen beneficiary copayments will decline as a share of the total payment until the beneficiary share is 20% of the Medicare fee schedule amount. A beneficiary copayment amount for a procedure is limited to the inpatient deductible amount established for that year. Balance billing is prohibited. | | |

## 13. Rural Health Clinics and Federally Qualified Health Center (FQHCs) Services

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Rural Health Clinics (RHCs) and Federally Qualified Health Center (FQHCs) services | RHCs and FQHCs are paid on the basis of an all-inclusive rate for each beneficiary visit for covered services. An interim payment is made to the RHC or FQHC based on estimates of allowable costs and number of visits; a reconciliation is made at the end of the year based on actual costs and visits. Per-visit payment limits are established for all RHCs (other than those in hospitals with fewer than 50 beds) and FHQCs. Assignment is mandatory; no deductible applies for FHQC services. | Payment limits are updated on January 1 of each year by the Medicare economic index (MEI) which measures inflation for certain medical services. | For **CY2008,** the RHC upper payment limit is $75.63 (compared to $74.29 in 2007), the urban FQHC limit is $117.41 (compared to $115.33 in 2007), and the rural FQHC limit is $100.96 (compared to $99.17 in 2007). |

## 14. Comprehensive Outpatient Rehabilitation Facility (CORF)

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Comprehensive Outpatient Rehabilitation Facility (CORF) | CORFs provide (by or under the supervision of physicians) outpatient diagnostic, therapeutic and restorative services. Payments for services are made on the basis of the physician fee schedule. Therapy services are subject to the therapy limits (described above for physical and occupational therapy providers). | See physician fee schedule and outpatient physical and occupational therapy services. | See physician fee schedule and outpatient physical and occupational therapy services. |

## 15. Part B Drugs/Vaccines Covered Incident to a Physician's Visit

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Drugs/vaccines. Medicare covers approximately 450 outpatient drugs and biologicals under the Part B program that are authorized by statute, including those: (1) that are covered if they are usually not self-administered and are provided incident to a physician's services; (2) those that are necessary for the effective use of covered DME; (3) certain self-administered oral cancer and anti-nausea drugs (those with injectable equivalents); (4) erythropoietin (used to treat anemia); (5) immunosuppressive drugs after covered Medicare organ transplants; (6) hemophilia clotting factors; and (7) vaccines for influenza, pneumonia, and hepatitis B. | Drug products, except for pneumococcal, influenza, and hepatitis B vaccines, those associated with certain renal dialysis services, blood products and clotting factors and radiopharmaceuticals, are paid using the average sales price (ASP) methodology. Alternatively, payment may be made through the competitive acquisition program which is currently under development. Medicare's payment under the ASP methodology equals 106% of the applicable price for a multiple source drug or single source drug subject to beneficiary deductible and coinsurance amounts. Regular Part B cost sharing applies, except for pneumococcal and influenza virus vaccines. Assignment is mandatory. | The ASP is updated quarterly by the Secretary. Payments under the ASP method will be lowered if the ASP exceeds the widely available market price or average manufacturer price by a specified percentage (5% in 2006 to present, as determined by the Secretary). Where the percentage is exceeded, the Secretary could adjust the payment amount; in such cases, the payment would equal the lesser of the widely available market price or 103% of the average manufacturer price. Several OIG reports found that the percentage was exceeded for some drugs and the Secretary has chosen not to exercise the option of lowering the payment rate for these drugs. | No specific provision. |

## 16. Blood

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Blood | Medicare pays the reasonable cost for pints of blood, starting with the fourth pint, and blood components that are provided to a hospital outpatient as part of other services. (Blood that is received in an IPPS hospital is bundled in the DRG payment.) For IPPS-excluded hospitals, Medicare pays allowable costs for blood. Beneficiary pays for first three pints of blood in a year, after which regular Part B cost sharing applies. | There is no specific update for the reimbursement of Part B blood costs. The outpatient facility is paid 100% of its reasonable costs as reported on its cost-reports. See the section on IPPS hospitals for updates for blood included as part of these hospitals. | No specific update. |

## 17. Partial Hospitalization Services Connected to Treatment of Mental Illness

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Partial hospitalization services connected to treatment of mental illness | Medicare provides Part B hospital outpatient care payments for "partial hospitalization" mental health care. The services are covered only if the individual would otherwise require inpatient psychiatric care. Services must be provided under a program which is hospital-based or hospital-affiliated and must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care. The program may also be covered when provided in a community mental health center. Payment for professional | See physician fee schedule and hospital outpatient services. | See physician fee schedule and hospital outpatient services. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | services is made under the physician fee schedule. Other services are paid under the hospital outpatient prospective payment system. Regular Part B cost sharing applies; balance billing is prohibited. | | |

## 18. Ambulance Services

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Ambulance services | Ambulance services are paid on the basis of a national fee schedule, which is being phased-in. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. The ground ambulance categories are: basic life support (BLS), both emergency and nonemergency; advanced life support Level 1 (ALS1), both emergency and nonemergency; advanced life support Level 2 (ALS2); speciality care transport (SCT); and paramedic ALS intercept (PI). The air ambulance categories are: fixed wing air ambulance (FW) and rotary wing air ambulance (RW). | The fee schedule amounts are updated each year by the CPI-U. | The update for **2008** is 2.7% (compared to 4.3% in 2007). Other provisions may will change the applicable rate. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | The national fee schedule is fully phased-in for air ambulance services. For ground ambulance services, payments through 2009 are equal to the greater of the national fee schedule or a blend of the national and regional fee schedule amounts. The portion of the blend based on national rates is 80% for 2007-2009. In 2010 and subsequently, the payments in all areas will be based on the national fee schedule amount.<br><br>The payment for a service equals a base rate for the level of service plus payment for mileage. Geographic adjustments are made to a portion of the base rate. For the period July 1, 2004 to December 31, 2009, mileage payments are increased by 22.6% for ground ambulance services originating in rural, low population density areas. There is a 25% bonus on the mileage rate for trips of 51 miles and more from July 2004 - December 2008. Regular Part B cost sharing applies. Assignment is mandatory. | | |

# Parts A and B

## 1. Home Health

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| Home health services | Home health agencies (HHAs) are paid under a prospective payment system that began in FY2001. Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits, medical supplies, and others. Durable medical equipment is not included in the home health (HH) PPS. The base payment amount is adjusted for: (1) differences in area wages using the hospital wage index; (2) differences in the care needs of patients (case mix) using "home health resource groups" (HHRGs); (3) outlier visits (for the extraordinarily costly patients); (4) a significant change in a beneficiary's condition (SCIC); (5) a partial episode for when a beneficiary transfers from one HHA to another during a 60-day episode; (6) budget neutrality; and (7) a low utilization payment adjustment (LUPA) | The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the HH market basket (MB) index. This index measures changes in the costs of goods and services purchased by HHAs.<br><br>DRA specified that HHAs that submit the data for purposes of measuring health care quality, as specified by the Secretary would receive a full MB increase; while HHAs that do not submit such data would receive an update equivalent to the MB update minus 2 percentage points. This requirement was applicable for CY 2007 and each subsequent year thereafter.<br><br>In CY 2008, refinements to the Medicare HH PPS were made that included a reduction in the national standardized 60-day episode payment rate for 4 years to | **For CY2007**, HHAs that submit the required quality data using OASIS received a MB update of 3.3%. For HHAs that do not submit these data, the update was reduced by 2 percentage points to 1.3%. **For CY2008**, the proposed HH MB update is 3.0%. For HHAs that fail to submit the required quality data, the HH MB update will be reduced by 2 percentage points to 1.0%. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | for beneficiaries who receive four or fewer visits. There is no difference between urban and rural base payment amounts.<br><br>The HHRG applicable to a beneficiary is determined following an assessment of the patient's condition and care needs using the Outcome and Assessment Information Set (OASIS). After the assessment, a beneficiary is categorized in one of 80 HHRGs that reflect the beneficiary's clinical severity, functional status, and service requirements.<br><br>HHAs are paid 60% of the case-mix and wage-adjusted payment after submitting a request for anticipated payment (RAP). The RAP may be submitted at the beginning of a beneficiary's care once the HHA has received verbal orders from the beneficiary's physician and the assessment is completed. The remaining payment is made when the beneficiary's care is completed or the 60-day episode ends. | account for changes in case mix that are not related to home health patients' actual clinical conditions; changes to the case-mix model to account differently for comorbidities and the differing health characteristics of longer-stay patients; changes to the way the PPS accounts for for the impact of rehabilitation services on resource use to reduce the impact of financial incentives on the delivery of therapy visits; and an increased payment for LUPA episodes that occur as the only episode or the first episode during a period of HH to account for front-loading of costs; among other changes. | |

## 2. End-Stage Renal Disease

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| End-stage renal disease | Dialysis services are offered in three outpatient settings: hospital-based facilities, independent facilities, and the patient's home. There are two methods for payment. Under Method I, facilities are paid a prospectively set amount, known as the composite rate, for each dialysis session, regardless of whether services are provided at the facility or in the patient's home. The composite rate is derived from audited cost data and adjusted for the national proportion of patients dialyzing at home versus in a facility, and for area wage differences. Adjustments are made to the composite rate for hospital-based dialysis facilities to reflect higher overhead costs. Beneficiaries electing home dialysis may choose not to be associated with a facility and may make independent arrangements with a supplier for equipment, supplies, and support services. Payment to these suppliers, known as Method II, is made on the basis of reasonable charges, limited to 100% of the median hospital composite rate, except for patients on continuous cycling | MMA provides for update to the composite rate beginning January 1, 2005. Beginning April 1, 2005 the composite rate will be case-mixed adjusted, budget neutrally. The Secretary is required to update the basic wage-adjusted case-mix payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate. | For CY2008, only the drug add-on adjustment of the composite rate is increased, by 0.5 percent. As a result, the drug add-on adjustment to the composite rate payment increased from 14.9.% to 15.5%. Additionally, the wage data was updated, implementing the third year of the wage index transition using a 25/75 blended wage adjusted composite rate (based 25% on an ESRD facility's Metropolitan Statistical area [MSA] designations and 75% on its Core Based Statistical area [CBSA] geographic area designations). |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | peritoneal dialysis, when the limit is 130% of the median hospital composite rate. Assignment is mandatory; regular Part B cost sharing applies. Kidney transplantation services, to the extent they are inpatient hospital services, are subject to the PPS. However, kidney acquisition costs are paid on a reasonable cost basis.<br>MMA required the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services furnished either at a facility or in a patient's home, for services furnished beginning on January 1, 2005. The basic case-mix adjusted system has two components: (1) the composite rate, which covers services, including dialysis; and (2) a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General Reports. | | |

# Part C

## Managed Care Organizations

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| (a) Medicare advantage contracts | In general, Medicare makes a monthly payment in advance to participating Medicare Advantage (MA) health plans for each enrolled beneficiary in a payment area. In exchange, the plans agree to furnish all Medicare-covered items and services to each enrollee. For most MA plans, the actuarial value of basic cost sharing, less any reduced cost sharing resulting from plan savings, may not exceed the actuarial value of cost sharing under original Medicare. Congress made substantial changes to the Medicare+Choice program with the passage of the MMA in 2003. The act created the Medicare Advantage (MA) program, which replaced the M+C program and introduced several changes designed to increase the availability of private plans for Medicare beneficiaries. In addition to the immediate payment increases to plans, beginning in 2006 the MA program changed the payment structure and introduced regional plans that operate like Preferred Provider Organizations. Additionally, | The MA rates are recalculated annually by the method described under "General Payment Policy."<br><br>The benchmark for MA plans is updated annually by the minimum percentage increase, or 100% of FFS in certain years. The minimum percentage increase is the greater of: (1) a 2% increase over the prior year's rate, or (2) the national MA growth percentage (*projected increase in Medicare per capita expenditures*). In years when the Secretary decides to rebase FFS rates, the benchmark is updated by the greater of: (1) a 2% increase over the prior year's rate, (2) the national MA growth percentage, or (3) 100% of FFS. After determining the annual update, the Secretary adjusts the benchmark for the health status of enrollees (risk adjustment) and budget neutrality.<br><br>Beginning in 2004 and at a minimum every third year, the Secretary is required to rebase FFS payment rates. Rebasing | For **2008**, in each county, the MA benchmarks will be updated by the national MA growth percentage or 5.71%.<br><br>Most recently, the DRA made changes to the calculation of the benchmark. Beginning in 2007, benchmarks continue to be updated by the minimum percentage increase, or 100% of FFS in certain years. However, the DRA added two new adjustments to calculating the benchmark: (1) an adjustment to exclude any national adjustment factors for coding intensity, and (2) an adjustment to exclude budget neutrality in risk adjustment for years 2007 through 2010. For purposes of calculating the phase-out of budget neutrality in risk adjustment, the Secretary is required to conduct a study of the difference between treatment and coding patterns between MA plans and providers under Parts A and B of Medicare. The findings are to be incorporated into calculations of MA benchmarks in 2008, 2009, and 2010. |

| **Provider/service** | **General payment policy** | **General update policy** | **Most recent update** |
|---|---|---|---|
| | beneficiaries had access to a drug plan whether they were enrolled in FFS Medicare or managed care. Finally, beginning in 2010 a limited number of geographic areas will be selected to examine enhanced competition between local MA plans and competition between private plans and FFS Medicare.<br>In 2006, the Secretary began determining MA plan payments by comparing plan *bids* to a *benchmark*. A plan's bid is its estimate of the cost of providing Part A and B Medicare services to beneficiaries. A benchmark is the maximum amount the federal government is willing to pay a plan for providing these required benefits. If a plan's bid is less than the benchmark, its payment is equal to its bid plus a rebate of 75% of the difference between its bid and the benchmark. The remaining 25% of the difference is retained by the federal government. If a plan's bid is greater than the benchmark, its payment is equal to the benchmark amount and the plan must make up the difference between its bid and the benchmark by charging a beneficiary premium. The Secretary has the authority to review and negotiate plan bid amounts to ensure that the bid reflects revenue requirements. At least | is updating FFS rates to reflect recent growth in county health care costs. The Secretary rebased FFS rates in 2007 and will not be rebasing in 2008, so the benchmark amount for 2008 will be the greater of 2% over the prior year's rate or the national MA growth percentage.<br><br>The update to the benchmark for regional plans has both a statutory increase and a competitive increase. The statutory component is similar to the update for other MA plans and the competitive component is based on a weighted average of plan bids. | The Secretary has not been able to make an adjustment for coding intensity as required as they are continuing to study the issue.<br><br>Eliminating budget neutrality for risk adjustment would not occur in any year if it would increase payments. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | one plan offered by an MA organization must be an MA-PD plan, one that offers Part D prescription drug coverage. MA organizations offering prescription drug coverage receive a direct subsidy for each enrollee in their MA-PD plan, equal to the plan's risk adjusted standardized bid amount (reduced by the base beneficiary premium). The plans also receive a reinsurance payment amount for the federal share of their payment as well as premium and cost-sharing reimbursements for qualified low-income enrollees.<br>Also beginning in 2006, the MA program began offering regional plans covering both in- and out-of-network required Medicare services. To encourage regional plan participation in the program, Congress authorized various financial incentives. For years 2006 and 2007, Medicare shared risk with plans whose costs fell above or below certain statutorily defined risk corridors. Additional payments were also authorized for hospitals in areas that demonstrate high costs. Finally, Congress created a stabilization fund to provide incentives for regional plans to enter into and to remain in the MA program. The stabilization fund was | | |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | initially funded at $10 billion for years 2007 through 2013. However, several pieces of legislation introduced after the MMA reduced the size of the fund and delayed its availability. Most recently, in December 2007 Congress reduced the amount available for the stabilization fund to $1.79 billion for year 2013.<br>A six-year program will begin in 2010 to examine comparative cost adjustment (CCA) in designated CCA areas. Payments to MA plans in CCA areas will, in part, be based on competitive bids. Also, Part B premiums for individuals enrolled in traditional Medicare may be adjusted, either up of down. This program will be phased-in and there is also a 5% annual limit on the adjustment, so that the amount of the adjustment to the beneficiary's premium for a year can not exceed 5% of the amount of the monthly Part B premium, in non-CCA areas. | | |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| (b) Cost contracts | Medicare pays cost contract health maintenance organizations (HMOs) and competitive medical plans (CMPs) the actual costs they incur for furnishing Medicare-covered services (less the estimated value of required Medicare cost sharing), subject to a test of "reasonableness." Interim payment is made to the HMO/CMP on a monthly per capita basis; final payment reconciles interim payments to actual costs. | No specific update. Cost-based HMOs are paid 100% of their actual costs. | Beginning January 1, 2009, cost contracts can not be extended or renewed in a service area if, during the entire previous year, the service area had two or more MA regional plans or two or more MA local plans meeting the following minimum enrollment requirements: (1) at least 5,000 enrollees for the portion of the area that is within a metropolitan statistical area having more than 250,000 people and counties contiguous to such an area, and (2) at least 1,500 enrollees for any other portion of such area. |

# Part D

## Outpatient Prescription Drug Coverage

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| **Part D drug coverage**. Outpatient prescription drug coverage is provided through private prescription drug plans (PDPs) or MA prescription drug (MA-PD) plans. The program relies on these private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies cover the | Federal payments to plans are linked to "standard coverage." Qualified Part D plans are required to offer either "standard coverage" or alternative coverage, with at least actuarially equivalent benefits. In 2008, most plans offer actuarially equivalent benefits or enhanced coverage rather than the standard | The definition of standard coverage is updated annually based on the estimated increase in per capita costs for the 12 month period ending the previous July. | In 2008, "standard coverage" has a $275 deductible, 25% coinsurance for costs between $276 and $2,510. From this point, there is no coverage until the beneficiary has out-of-pocket costs of $4,050 ($5,726.25 in total spending); this coverage gap has been labeled the "doughnut hole." Once the beneficiary reaches the |

| Provider/service | General payment policy | General update policy | Most recent update |
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| bulk of the risk. Unlike other Medicare services, the benefits can only be obtained through private plans. While all plans have to meet certain minimum requirements, there are significant differences among them in terms of benefit design, beneficiary premiums amounts, drugs included on plan formularies (i.e. list of covered drugs) and cost sharing applicable for particular drugs. | package. A number of plans have reduced or eliminated the deductible. Many plans offer tiered cost sharing under which lower cost sharing applies for generic drugs, higher cost sharing applies for preferred brand name drugs, and even higher cost sharing applies for non-preferred brand name drugs. Some plans provide some coverage in the coverage gap (“doughnut hole”); this is generally limited to generic drugs. | | catastrophic limit, the program pays all costs except for nominal cost sharing. |
| **Federal Subsidy Payments** | Federal subsidy payments (including both direct payments and reinsurance payments) are made to plans consistent with an overall subsidy level of 74.5% for basic coverage. Direct monthly per capita payments are made to a plan equal to the plan’s standardized bid amount adjusted for health status and risk and reduced by the base beneficiary premium, as adjusted to reflect the difference between the bid and the national average bid. Reinsurance payments, equal to 80% of allowable costs, are provided for enrollees whose costs exceed the annual out-of-pocket threshold ($4,050 in 2008). | Payments to plans are calculated annually by the method described under “General Payment Policy.” | Federal payments were recalculated for the 2008 plan year. |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| **Beneficiary Premiums** | Beneficiary premiums represent on average 25.5% of the cost of the basic benefit. A base beneficiary premium is calculated based on the national average monthly bid amount for basic coverage. This amount is adjusted, up or down as appropriate, to reflect differences between the plan's standardized bid amount and the national average monthly bid amount. It is further increased for any supplemental benefits and decreased if the individual is entitled to a low-income subsidy. The premium is the same for all individuals in a particular plan (except those entitled to a low income subsidy). | Beneficiary premiums are calculated annually by the method described under "General Payment Policy." | Beneficiary premiums were recalculated for the 2008 plan year. |
| **Risk corridors** | The federal government and plans share the risk for costs within specified "risk corridors."Risk corridors" are specified percentages for costs above and below a target amount; the target amount is defined as total payments paid to the plan taking into account the amount paid to the plan by the government and enrollees. | In 2006 and 2007, plans were at full risk for costs within 2.5% above or below the target. If costs were between 2.5% and 5% above the target, they were at risk for 25% of spending between 2.5% and 5% of the target and 20% of spending above that amount. If plans fell below the target, they have to refund 75% of the savings if costs fall between 2.5% and 5% below the target and 80% of any amounts below 5% of the target. For 2008-2011, risk corridors are | The 2008 risk corridors are modified, as described under "General Update Policy." |

| Provider/service | General payment policy | General update policy | Most recent update |
|---|---|---|---|
| | | modified. Plans are at full risk for spending within 5% above or below the target. They are at risk for 50% of spending between 5% and 10% of the target and 20% of any spending exceeding 10% of the target. | |

# CRS Reports for Additional Information

CRS Report RL33712, *Medicare: A Primer*, by Jennifer O'Sullivan

CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, by Jennifer O'Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer L. Boulanger, and Paulette C. Morgan

CRS Report RL34360, *P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007*, by Hinda Chaikind, Jim Hahn, Jeane Hern, Elicia J. Harz, Gretchen A. Jacobson, Paulette C. Morgan, Chris L. Peterson, Holly Stockdale, Jennifer O'Sullivan, and Julie Stone

CRS Report RS20173, *Medicare: Financing the Part A Hospital Insurance Program*, by Jennifer O' Sullivan

CRS Report RS20946, *Medicare: History of Part A Trust Fund Insolvency Projections*, by Jennifer O'Sullivan

CRS Report RS22796, *Medicare Trigger*, by Hinda Chaikind and Christopher M. Davis

CRS Report RL31199, *Medicare: Payments to Physicians*, by Jennifer O'Sullivan

CRS Report RS22769, *Medicare Clinical Laboratories Competitive Bidding Demonstration*, by Barbara English

CRS Report RL32582, *Medicare: Part B Premiums*, by Jennifer O'Sullivan

CRS Report RS21731, *Medicare: Part B Premium Penalty*, by Jennifer O'Sullivan

CRS Report RL34151, *Private Fee for Service (PFFS) Plans: How They Differ from Other Medicare Advantage Plans*, by Paulette C. Morgan, Hinda Chaikind, and Holly Stockdale

CRS Report RL34280, *Medicare Part D Prescription Drug Benefit: A Primer*, by Jennifer O'Sullivan

# CRS Staff, by Medicare Issue

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| Inpatient Rehabilitation Facilities | Sibyl Tilson | 7-7368 |
| Medical Devices | Gretchen Jacobson | 7-1686 |
| Skilled Nursing Facilities | Julie Stone | 7-1386 |
| **Part B** | | |
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| Durable Medical Equipment | Paulette Morgan | 7-7317 |
| Outpatient Hospital Services | Sibyl Tilson | 7-7368 |
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| SGR options | Jennifer O'Sullivan<br>Jim Hahn | 7-7359<br>7-4914 |
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| **Part D** | | |
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| Quality Improvement Organizations | Holly Stockdale | 7-9553 |
| **Other** | | |
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| Medicare Trigger | Hinda Chaikind | 7-7569 |
| Medicare HI & SMI Trust Fund Financing | Jennifer O'Sullivan | 7-7359 |
| Pay for Performance/Value-Based Purchasing | Jim Hahn | 7-4914 |
| Price Transparency | Jim Hahn | 7-4914 |
| Rural Issues | Sibyl Tilson | 7-7368 |