CHAPTER 1

How Medicare pays for services: an overview

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Medicare's 40 million beneficiaries use thousands of different health care products and services furnished by over 1 million providers in hundreds of markets nationwide. Medicare pays for these services using 15 payment systems that are generally organized by delivery setting. These payment systems share common goals and most have similar design elements that are tailored to accommodate the products Medicare is buying in each setting, the characteristics of the providers that produce them, the extent to which the same product may be furnished in different settings, and the market circumstances that affect providers' costs. In this chapter, we describe the key features of these payment systems and summarize related policy issues in each service setting.

Medicare was enacted to improve access to care by reducing the financial burdens faced by elderly (and later disabled) people in obtaining medically necessary acute care services. To achieve this objective, Medicare helps its beneficiaries pay for covered products and services in 15 different health care settings. These settings encompass the full range of health care, including facility services—provided in hospital inpatient and outpatient departments, ambulatory care centers, and skilled nursing facilities, for example—and professional services furnished by physicians, therapists, and other practitioners.

In the traditional fee-for-service (FFS) program, Medicare sets prospectively the payment amounts (rates) providers will receive for most covered products and services and providers agree to accept them as payment in full.[1] Thus, in most instances, providers' payments are based on predetermined rates and are unaffected by their costs or posted charges. When beneficiaries use services, providers submit bills to Medicare's fiscal agents, who pay the predetermined rates minus beneficiaries' cost-sharing liabilities, such as deductibles and coinsurance. Providers then collect the remaining amounts from beneficiaries.[2]

In the Medicare+Choice (M+C) program, Medicare sets the county-specific monthly capitation payment rates that M+C organizations will receive for enrolled beneficiaries. M+C plans may offer beneficiaries additional benefits not covered in the traditional program and charge additional premiums if the total cost of all covered benefits exceeds Medicare's capitation payment rates. M+C plans, however, accept responsibility for contracting with and paying health care providers and suppliers for the products and services they furnish to enrolled beneficiaries.

In 2000, Medicare's program payments for covered services amounted to $213 billion, representing 12 percent of total federal spending. Beneficiaries' financial liabilities amounted to an additional $35 billion.

Recent legislation—the Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)—fundamentally changed the way Medicare pays for many products and services. These laws required the Centers for Medicare & Medicaid Services (CMS)[3] to develop and adopt new prospective payment systems (PPSs) for services furnished by skilled nursing facilities, hospital outpatient departments, home health agencies, rehabilitation facilities, long-term care hospitals, and psychiatric facilities; they also required CMS to change the method for making prospective capitation payments to health care organizations under the M+C program. In addition, CMS has modified its PPSs for hospital inpatient acute care and physician services, and proposed changing its payment methods for durable medical equipment and ambulance services.

Under the law, the Medicare Payment Advisory Commission (MedPAC) must evaluate the design and implementation of Medicare's payment systems and make recommendations to the Congress and the Secretary of Health and Human Services (HHS) to address any problems. In addition, we make annual recommendations to the Congress on how payment rates should be updated (see Chapter 2). To carry out these responsibilities, we must have a clear understanding of Medicare's payment policy objectives, the major features of its payment systems, and how the features work to produce results that are (or are not) consistent with payment objectives.

Policymakers, providers, and others interested in understanding current Medicare payment issues and their implications also must begin with the basic features of these payment systems.

In this chapter, we describe the 15 major payment systems Medicare uses to pay providers for products and services they furnish to its beneficiaries. We also give a brief summary of current policy issues for each payment system. We begin with an overview of key structural elements that are present—explicitly or implicitly—in virtually all prospective payment systems. This overview is followed by six sections that describe the payment systems, grouped as follows:

- inpatient acute care in short-term hospitals and psychiatric facilities;
- ambulatory care furnished by physicians, hospital outpatient departments, ambulatory surgical centers, and clinical laboratories;
- post-acute care furnished by skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals;
- dialysis services furnished in outpatient centers and hospice care;
- ambulance services and products furnished by durable medical equipment suppliers; and
- services furnished by private health plans under the M+C program.

The 15 payment systems have substantially different spending patterns (Figure 1-1). For example, in 2000, program payments plus payments by beneficiaries (or third-party payers on their behalf) for inpatient acute care in short-term hospitals, physician services, and M+C plans accounted for 70 percent of Medicare spending.

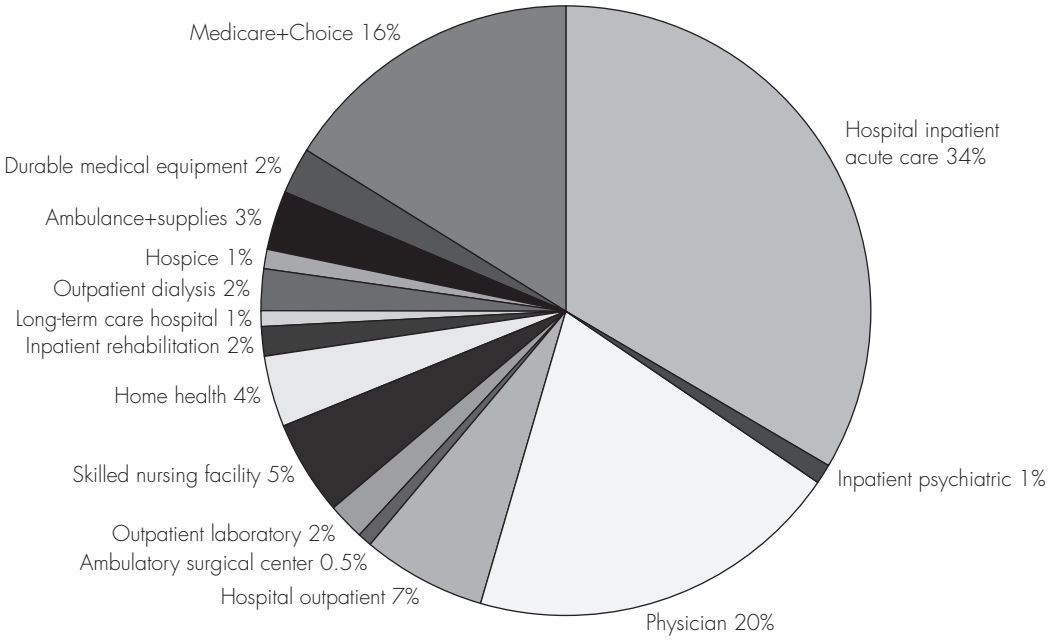
1 Medicare pays for some services—those furnished by long-term care hospitals and psychiatric facilities, for example—based on a provider's incurred allowable costs. In these instances, providers receive interim payments, usually reflecting their unit costs in the preceding year; discrepancies between interim payments and allowable costs are resolved (settled) annually after the end of the provider's cost reporting period.

2 Most beneficiaries have secondary insurance; in this case, Medicare's fiscal agents generally bill the secondary payer directly for the beneficiary's liability.

3 CMS was formerly known as the Health Care Financing Administration.

FIGURE 1-1

Distribution of Medicare spending, by service setting, 2000



Note: Spending shares reflect total payments, including program payments and those made by beneficiaries and by third-party payers on their behalf; percentages do not sum to 100 due to rounding.

Source: Centers for Medicare & Medicaid Services.

Key structural elements of Medicare's prospective payment systems

Medicare's payment policies and methods are often seen as extremely complex, a perception strengthened by the myriad policy changes enacted in recent legislation. Even without these changes, however, Medicare's size and scope—buying a full range of health care products and services from many different types of providers in hundreds of markets nationwide—would make its payment methods complicated. Further complexity stems from the current mix of payment systems in which traditional payment methods based on providers' costs and charges have not yet been fully replaced by prospectively determined payment rates.

Nevertheless, Medicare's payment systems reflect common goals and problems that are addressed using a handful of similar structural elements. Focusing on the goals and design elements helps make these payment systems and related policy issues more understandable.

As discussed in previous MedPAC reports, Medicare's prospective payment systems are intended to support its principal policy objective—ensuring beneficiaries' access to high-quality care in the most appropriate clinical setting without imposing undue financial burdens on beneficiaries or taxpayers (MedPAC 2001c, MedPAC 1999). To achieve this objective, Medicare's payment systems must set payment rates that are consistent with efficient providers' short-run marginal costs of producing services. That is, payment rates must accurately reflect predictable cost variations among products and services and those associated with patient or beneficiary characteristics and local market factors that are beyond providers' control.

To set and maintain accurate payment rates for many products and services—even in a single setting—is a difficult task. At a minimum, policymakers need certain tools (Table 1-1):

- the products and services Medicare is buying must be well defined,
- the relative costliness of each product or service compared with that of the average service unit must be measurable,
- production processes used by providers must be understood well enough to identify the major inputs that contribute to efficient providers' unit costs,
- patient or beneficiary characteristics and market circumstances that may

TABLE 1-1

Summary of Medicare's current payment systems by setting

	Acute inpatient care		Ambulatory care				Post-acute care	
Payment system description	**Acute care hospitals**	**Psychiatric facilities**	**Physicians**	**Hospital outpatient departments**	**Ambulatory surgical centers**	**Outpatient laboratories**	**Skilled nursing facilities**	**Home health agencies**
Fiscal year began	1984	1983	1992	2000	1982	1984	1998	2001
Basis of payment	Prospective	Facility costs with limit	Prospective	Prospective	Prospective	Prospective	Prospective	Prospective
Product definition								
Unit of payment	Discharge	Discharge	Service	Service	Procedure	Test	Day	60-day episode
Product classification system	506 DRGs	None	7,000+ HCPCS codes	HCPCS grouped in 750 APCs	HCPCS in 8 procedure groups	1,100+ HCPCS codes	44 RUG-III groups	80 HHRGs
Policies defining product boundaries	72-hour rule short-stay transfers; high-cost outliers	None	Differentials by setting, multiple or atypical services	High-cost outliers; multiple service discount	Multiple service discount	None	None	Fewer than 5 visits; high-cost outliers
Product relative values								
Components of relative values	Single value for each DRG	None	Physician work; practice expenses; liability insurance	Single value for each APC	Single amount for each group	Combined with base amount	Therapy services; nursing care	Single value for each HHRG
Source of relative values	Hospitals' billed charges	None	Expert judgement; practice expense data; premium survey	Median of estimated service costs	Median of estimated service costs	None	Staff-time studies	Estimated mean cost per HHRG
Base payment rate/conversion factor								
Components of base amount	Labor-related; nonlabor; capital	Current per unit operating costs	Single conversion factor (for sum of relative values)	Labor-related; other	Labor-related; other	Carrier-specific rates with limit	Therapy; nursing care; routine care	Labor-related, other
Source of base amount	Updated providers' 1982 costs	Facility's annual cost report	Projected spending under preceding method	1996 OPD charges adjusted to costs	1986 survey of ASCs	Updated 1983 lab charges	Target aggregate spending	Spending in preceding system

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affect providers' costs must be known and measurable, and

- a payment update method must be developed to adjust payment rates annually, consistent with changes in input prices and other factors that may affect efficient providers' costs over time.

Defining the products and services Medicare is buying

The products Medicare buys in each setting are defined by the unit of payment and a compatible classification system. The unit of payment may be an individual service (a physician office visit, for example), a day of care (care in a skilled nursing facility), an episode of care (a hospital stay), or a month of service (as in the M+C program). Generally, the unit of payment should match the unit of service and the way providers think about delivering care in the setting.

Consistent with the unit of payment, the classification system identifies distinct services, types of patient care products, or

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Adjustments for local market conditions								
Labor input prices	Hospital wage index (HWIr)	None	Separate GPCIs: work, practice expenses, PLI	Hospital wage index (HWIr)	Hospital wage index (HWIr)	None	Hospital wage index (HWIu)	Hospital wage index (HWIu)
Other input prices	COLA	None	None	None	None	None	None	None
Other payment adjustments	Low-income patients (DSH); GME programs	None	Reduced rates for nonphysician practitioners	None	None	None	None	None
Payment update method	Rise in hospital market basket index	Rise in TEFRA market basket index	SGR formula	Rise in hospital market basket index	Rise in CPI-U	Rise in CPI-U	Rise in SNF market basket index	Rise in home health market basket index
Payments for capital costs	Separate prospective rates	Separate cost pass-through	Included in payment rate	Included in payment rate	Included in payment rate	Included in payment rate	Included in payment rate	Included in payment rate
Other policies	Higher rates in large urban areas; policies for rural providers	National limit adjusted to reflect local market wage level	10 percent add-on for health professional shortage areas (HPSAs)	New technology pass-through; transitional corridors	None	National limit = median of carriers' rates	None	10 percent add-on for rural beneficiaries

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patients that are expected to require different amounts of resources. In some Medicare payment systems—the hospital inpatient PPS, for example—the classification categories reflect different clinical problems as indicated by diagnoses and procedures. In others, such as those for physician, hospital outpatient, or ambulatory surgical services, the categories reflect different procedures or evaluation and management services. In all payment systems, the classification categories define the products for which Medicare will pay.

Setting relative values

Relative values measure the expected costliness of a unit in each classification category compared with the overall average costliness of all units. Categories that require above-average resources have higher relative values and those that require fewer resources have lower ones. Relative values are often referred to as case-mix weights.

Setting a national base payment rate

The base payment rate represents the amount Medicare would pay for an average unit of service in the setting in a market with national average input prices, if no other payment adjustments applied. The base payment rate in each setting should reflect the costs the payment rates are intended to cover—operating costs alone or operating and capital costs together.[4]

Adjusting for local market conditions

Input prices differ among markets across the nation and these differences generally affect efficient providers' costs in predictable ways. Consequently, Medicare's payment rates in each market should be adjusted to reflect the local price level. To make these adjustments, policymakers must have one or more measures of geographic variation in input prices—such as the area wage index in the hospital inpatient acute care PPS or the geographic practice cost indexes in the physician fee schedule. Policymakers also must know what proportions of providers' unit costs are affected by variations in input prices. This information is used to determine how much of the national base

4 Operating costs consist of expenses for room, board, routine and special care, and ancillary services, such as laboratory tests, therapy, and imaging. Capital costs, such as rent, interest, and depreciation, are included in the payment rates in some payment systems (such as the skilled nursing facility PPS) or excluded and paid separately.

TABLE 1-1

Summary of Medicare's current payment systems by setting

	Post-acute care		Services for special populations		Other services		
Payment system description	**Inpatient rehabilitation facilities**	**Long-term care hospitals**	**Outpatient dialysis care**	**Hospice services**	**Ambulance services**	**Durable medical equipment**	**Medicare+Choice plans**
Fiscal year began	2002	1983	1982	1983	1966	1986	1998
Basis of payment	Prospective	Facility costs with limit	Prospective	Prospective	Costs or charges with cap	Prospective	Prospective
Product definition							
Unit of payment	Discharge	Discharge	Dialysis treatment	Day	Trip	Item	Month
Product classification system	385 CMGs	None	None	4 care type groups	HCPCS	HCPCS within 6 equipment categories	Beneficiaries' demographics and health risk
Policies defining product boundaries	short-stay outliers/deaths; transfers; high-cost outliers	None	None	Beneficiary gives up curative treatment	None	None	All-inclusive capitation payment rate
Product relative values							
Components of relative values	Single value for each CMG	None	None	Combined with base amounts	None	Combined with base amounts	One value for each enrollee category
Source of relative values	Hospitals' billed charges	None	None	None	None	None	FFS bills 1992–1996
Base payment rate/conversion factor							
Components of base amount	Labor-related; other	Current per unit operating costs	Labor-related; other	Labor-related; other	None	Single amount	Updated 2001 rate; blended national/ county rate
Source of base amount	Projected spending under preceding method	Facility's annual cost report	1977–1979 cost reports	Cost data from Medicare demonstration	None	Allowed charges in 1986–1987	Historical FFS spending in county and nation

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payment rate should be adjusted by the geographic input price factor for each market area. Most Medicare payment systems use a version of the hospital wage index.

Other adjustments

Most payment systems have other adjustments that reflect unusual characteristics of patients, services furnished, the providers, or the market areas in which providers operate. These adjustments generally are intended to reflect factors that are likely to substantially alter the resources needed to provide services or policymakers' decisions to support certain activities. Other adjustments are made for such things as providing graduate medical education, serving a disproportionate share of low-income patients, or furnishing services to rural beneficiaries. Some payment systems, such as the acute inpatient hospital PPS, have more adjustments than others.

Updating payment rates

Payment rates for most settings must be updated annually to reflect changes in technology, practice patterns, and market conditions. CMS must develop methods and data sources to be used in updating the base payment amount, the classification system, and the relative values. Other payment adjustments also may need periodic revision as conditions change.

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Adjustments for local market conditions							
Labor input prices	Hospital wage index (HWIu)	None	40% 1986 HWI + 60% 1980 BLS wage index	Hospice wage index	None	Carrier-specific rates with limit	Hospital wage index (HWIu); GPCIs
Other input prices	None	None	None	None	None	None	None
Other payment adjustments	Low-income patients	None	Higher rates for hospital-based facilities	None	None	Product-specific national limits	None
Payment update method	Rise in modified TEFRA market basket index	Rise in TEFRA market basket index	No routine update	Rise in hospital market basket index	Charge cap updated by rise in CPI-U	Rise in CPI-U	Rise in aggregate FFS spending; 2 percent minimum
Payments for capital costs	Included in prospective rates	Separate cost pass-through	Included in payment rate	Included in payment rate	Included in payment rate	Included in payment rate	Included in payment rate
Other policies	Higher rates in rural areas	National limit adjusted to reflect local market wage level	Exceptions; extra payments for some tests and drugs	Annual payment per beneficiary capped	Mileage may be paid separately	None	None

Note: APCs (ambulatory payment classifications), ASC (ambulatory surgical center), BLS (Bureau of Labor Statistics), CMGs (case-mix groups), COLA (cost of living adjustment, applied in Alaska and Hawaii), CPI-U (consumer price index–all urban consumers), DRGs (diagnosis related groups), FFS (fee-for-service), GME (graduate medical education), GPCIs (geographic practice cost indexes), HCPCS (HCFA Common Procedure Coding System),HHRGs (home health resource groups), HWIr (hospital wage index with geographic reclassifications), HWIu (hospital wage index unreclassified), OPD (outpatient department), PLI (professional liability insurance), RUG-III (resource utilization group, version III), SGR (sustainable growth rate), SNF (skilled nursing facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

In most payment systems, the national base payment rate is updated annually based on the forecasted increase in an industry-specific national input-price index called a market basket (MB) index. The MB index, developed by CMS, tracks national average price levels for labor and other inputs, weighted to reflect the relative importance of each input category in the specific industry.[5] This update affects all payment rates equally and does not affect the distribution of payments among product or service categories.

Updating the relative values affects the distribution of payments among products and services, and among providers according to their case or service mixes. In some payment systems, such as those for acute inpatient hospital care and inpatient rehabilitation services, relative values are updated annually. In other systems, such as the skilled nursing facility and home health PPSs, the relative values are updated less frequently.

The configuration of these elements varies widely among Medicare's payment systems, reflecting differences in the nature of the services Medicare is buying, the characteristics of the providers that produce them, and how market conditions affect providers' costs. In addition, Medicare's payment systems often include provisions designed to offset or weaken providers' financial incentives to shift beneficiaries' care among settings. These financial incentives reflect fixed-price payment for bundles of services—providers can lower their costs and increase profits by shifting the provision of some services to another setting where they would be paid for in a different

5 For physician services, CMS uses the Medicare Economic Index (MEI), a weighted average of price changes for inputs used to provide care. These include physician time and effort, wage rates for nonphysician employees, and office expenses. The MEI is similar conceptually to the market basket index (see Chapter 2), except that it includes an adjustment for productivity growth.

payment system. These incentives also may arise because Medicare sets payment rates separately for each setting and may pay different amounts for the same service, depending on the setting in which it is furnished.

The remainder of this chapter describes how the key elements are combined and current policy issues for each of the 15 payment systems Medicare uses to pay providers for services they furnish to its beneficiaries. At the end of the chapter, we list some useful sources for further information on how Medicare pays for services.

Acute inpatient services

This section describes Medicare's payment methods for acute inpatient care furnished to beneficiaries in:

- short-term general hospitals, and
- specialty psychiatric facilities.

Payment for acute care services in short-term general hospitals

About 20 percent of Medicare's beneficiaries enrolled in the traditional program use hospital inpatient services each year.[6] They receive care in more than 4,800 short-term general hospitals that contract with Medicare to provide services and agree to accept the program's predetermined payment rates as payment in full.[7] Payments for inpatient care (about $83 billion in 2000) account for the largest component—about 34 percent—of Medicare spending. These payments also provide the largest single source of hospitals' revenues—about 23 percent of overall revenues.

From its inception in 1966 until 1983, Medicare paid hospitals for inpatient services based on their incurred costs. This payment method gave providers little incentive to produce services efficiently. Because they were costly and relatively easy to distinguish, episodes of hospital inpatient care (stays) were the first to be converted to prospectively determined payment, beginning in fiscal year 1984. The hospital PPS is a mature system, but it nevertheless needs frequent adjustments to keep up with changes in technology, practice patterns, and market conditions that affect the amount and mix of resources hospitals use to furnish inpatient care.

The inpatient PPS pays hospitals predetermined per-discharge rates that are based primarily on two factors:

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

Using information about patients' diagnoses, procedures, ages, and discharge destinations reported on hospitals' claims, Medicare assigns discharges to diagnosis related groups (DRGs), which are designed to group patients with similar clinical problems that are expected to require similar amounts of hospital resources. Each DRG has a national relative weight that reflects the expected relative costliness of inpatient treatment for a patient in that group compared with that for the average Medicare patient. Groups expected to require above-average resources have higher weights and those that require fewer resources have lower ones. The payment rates for DRGs in each local market are determined by adjusting a national average base payment amount (the amount that would be paid for an average patient in a facility located in an average market) to reflect the input-price level in the local market, and then multiplying the adjusted local amount by the relative weight for each DRG. Payment rates also are increased for facilities that operate approved physician (resident) training programs, those that treat a disproportionate share of low-income patients, and for other factors.

Because the inpatient PPS accounts for a large share of Medicare spending, it faces ongoing scrutiny, often leading to technical and policy improvements. The inpatient PPS is intended to cover efficient providers' costs, thereby rewarding those whose costs fall below the payment rates. However, financial performance under the PPS differs substantially among certain groups of hospitals (see Chapter 2). These differences reflect some combination of desired effects of policies adopted by the Congress after careful deliberation, unintended results of inaccurate or inappropriate payment adjustments, and failures to address factors that affect efficient providers' costs in certain circumstances.

Defining the hospital inpatient acute care products Medicare buys

Under the inpatient PPS, Medicare sets per-discharge payment rates for distinct treatment episodes represented by 506 DRGs, which are based on patients' clinical conditions and treatment strategies.[8] Clinical conditions are described by patients' discharge diagnoses, including the principal diagnosis—the main problem requiring inpatient care—and up to eight secondary diagnoses indicating other conditions that were present at admission (comorbidities) or developed during the hospital stay (complications). The treatment strategy—surgical or medical treatment—is

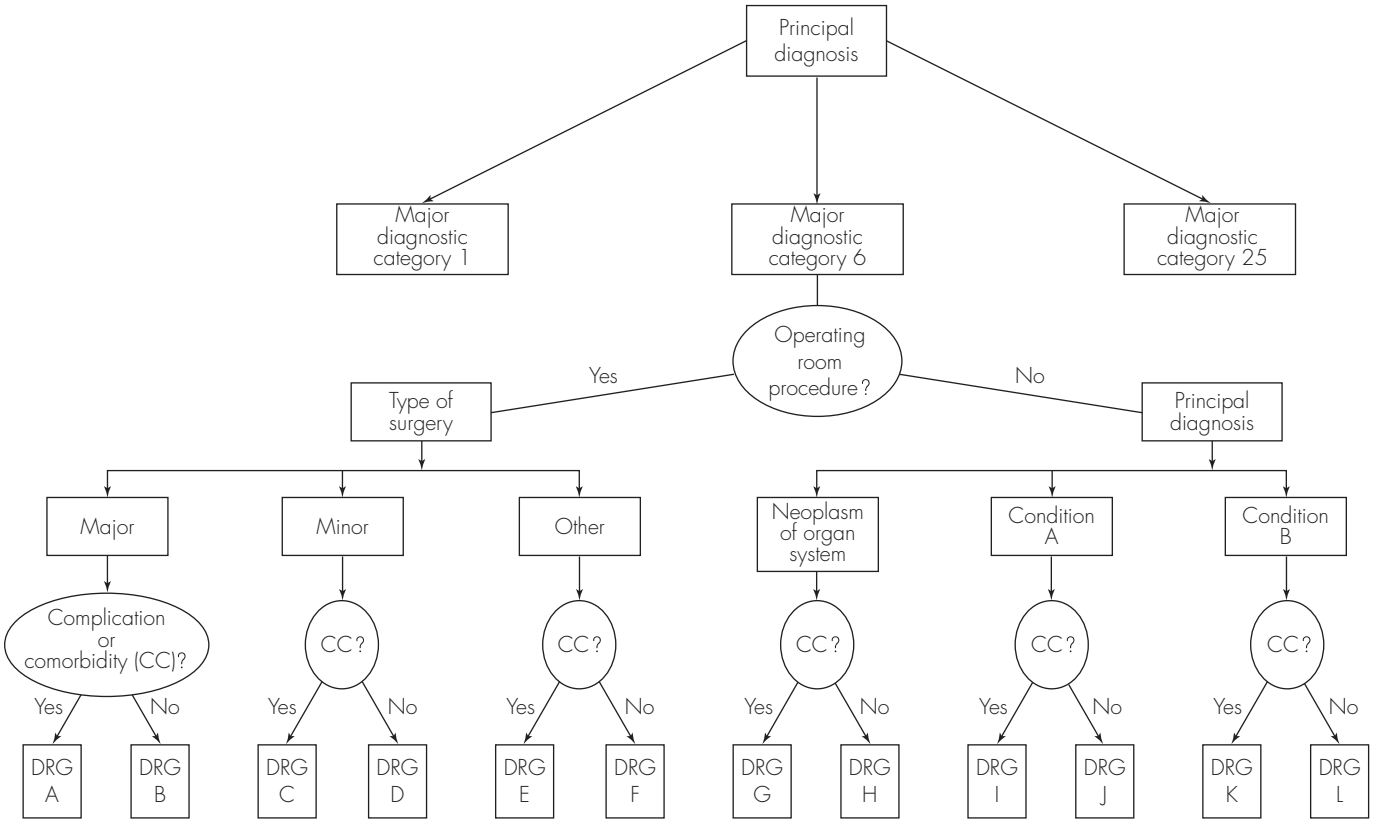
6 The Medicare inpatient hospital benefit covers beneficiaries for 90 days of care per illness episode, with a 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted for care and end after they have been out of the hospital or a skilled nursing facility for 60 consecutive days. Beneficiaries are liable for a deductible of $812 for the first hospital stay in an episode. Daily copayments—currently $203—are imposed beginning on the 61st day.

7 Except for convenience items or services not covered by Medicare, providers are not permitted to charge beneficiaries more than the predetermined payment rate. Medicare pays the predetermined rate minus any beneficiary liability, such as a deductible or copayment; the provider then collects the remaining amount from the beneficiary.

8 Although the federal DRG classification system includes 523 categories, 17 are no longer used for Medicare payment.

FIGURE 1-2

The general structure of diagnosis related group definitions



Note: Medicare uses 506 diagnosis related groups (DRGs) derived from 25 major diagnostic categories (MDCs). This diagram illustrates the logical structure of the DRG definitions for one MDC.

described by the presence or absence of up to six procedures performed during the stay. Age, sex, and discharge destination—for example, home, another PPS hospital, or a skilled nursing facility—are also occasionally used to distinguish groups of patients who are expected to use different amounts of resources.

The DRG definitions have a tree-like structure (Figure 1-2). Based on the principal diagnosis, cases are first assigned to one of 25 major diagnostic categories (MDCs), reflecting the affected organ system (such as the digestive system) or the etiology of the condition (such as burns or significant trauma). Within each MDC, cases are subdivided into those with and those without operating room or other significant procedures. Each of these broad groups is then further divided; the surgical group by type of procedure and the medical group by specific type of condition as indicated by the principal diagnosis. Finally, medical and surgical subgroups are often subdivided further to form DRGs distinguished by the presence or absence of comorbidities or complications indicated by specific secondary diagnoses.[9]

CMS annually reviews the DRG definitions to ensure that they continue to include cases with clinically similar conditions requiring comparable amounts of inpatient resources. When the review shows that clinically similar cases within a DRG consume atypical quantities of resources, CMS often reassigns them to a different DRG with comparable resource use; less often, CMS creates a new DRG.[10]

In return for Medicare's predetermined payment rates, hospitals are expected to furnish a reasonably well-defined bundle of inpatient services for each DRG. Facing fixed payment rates, however, providers have financial incentives to reduce their inpatient costs by moving some normally included services to another setting—such as an outpatient

9 These groups are sometimes divided further to form DRGs for pediatric patients (under age 17); a few DRGs are also distinguished by patient sex or discharge destination.

10 For example, CMS established a new DRG when it found that tracheostomy patients were substantially more costly than others in the same DRGs.

department or a skilled nursing facility—and billing those services separately. To counter these financial incentives, Medicare has adopted policies that help to strengthen the boundaries of the inpatient service bundles associated with the DRGs. Thus, patients must stay overnight before their discharges qualify for payment under the inpatient PPS. Related outpatient department services that were delivered in the three days before admission are included in the payment for the inpatient stay and may not be separately billed (the 72-hour rule). Similarly, payments for services may be reduced when patients are transferred to another hospital after a stay that is more than one day shorter than the national average stay for the DRG. The same payment reductions apply for certain DRGs when patients are transferred to rehabilitation or skilled nursing facilities or discharged to receive clinically related home health care.

Setting product payment rates

Medicare sets separate per-discharge operating and capital payment rates, which are intended to cover the operating and capital costs that efficient facilities would be expected to incur in furnishing covered inpatient services.[11] Operating payment rates cover costs for labor and supplies; capital payment rates cover costs for depreciation, interest, rent, and certain property-related expenses for insurance and taxes.

Medicare sets operating and capital payment rates using similar methods and factors. In general, CMS sets national payment rates for all types of cases by multiplying a base payment amount by the relative weight for each DRG. The DRG payment rates are then adjusted to reflect the local level of input prices in each market area. Finally, operating and capital payment rates are adjusted to account for certain hospital and case-specific factors.

The base payment amounts Medicare sets two separate operating base payment amounts (known as standardized payment amounts): one for large urban areas—metropolitan statistical areas (MSAs) with a population of one million or more—and one for all other urban and rural areas.[12] These base payment amounts represent what a hospital located in these areas would be paid for operating expenses for an average Medicare patient (before any adjustments). The base operating amounts per discharge for fiscal year 2002 are $4,157 for large urban areas and $4,091 for other areas.

Capital payments have only recently been made fully prospective, having completed a 10-year phase-in during fiscal year 2001.[13] The base capital rate for discharges from hospitals in large urban areas for fiscal year 2002 is $402; it is $391 for hospitals located in other areas.

The diagnosis related group relative weights Medicare assigns a weight to each DRG reflecting the average relative costliness of cases in that group compared with that for the average Medicare case. The same DRG weights are used to set operating and capital payment rates. CMS recalibrates the DRG weights annually based on average standardized billed charges for all PPS cases in each DRG in the most recent Medicare bill file.[14]

Adjustment for market conditions Medicare's base operating and capital payment rates are adjusted to reflect the expected impact on efficient providers' costs of differences in local market prices for labor and other inputs. The base operating payment is adjusted by an area wage index; in Alaska and Hawaii, a cost of living adjustment (COLA) is also applied. The area wage index is intended to measure differences in hospital wage rates among labor markets; it compares the average hourly wage for hospital workers in each MSA or statewide rural area relative to the nationwide average.[15] The wage index is applied to the labor-related portion of the standardized payment amount—71 percent of the total—which reflects CMS's estimate of the portion of operating costs affected by local wage rates and fringe benefits. The wage index is revised each year based on wage data reported by PPS hospitals on their annual Medicare cost reports. The COLA reflects the higher costs of supplies and other nonlabor resources in Alaska and Hawaii; it increases the nonlabor portion of PPS operating payments—29 percent of the total—for hospitals in these states by as much as 25 percent.

The federal rate for capital payments is adjusted to reflect local market conditions using a geographic adjustment factor (which is based on the area wage index) and, for Alaska and Hawaii, the same COLA.

Other adjustments Payment rates also may be adjusted to reflect higher costs of care in hospitals that operate approved resident training programs, revenue losses associated with treating low-income patients, and the financial burden of exceptionally high-cost cases. These adjustments are intended to preserve access to care for Medicare beneficiaries by protecting hospitals that face certain

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

12 Hospitals in Puerto Rico receive a 50/50 blend of the federal base payment amount and a Puerto Rico-specific rate.

13 New hospitals are exempt from prospective payment for capital costs for two years. During this period, they are paid 85 percent of their allowable capital costs.

14 Hospitals' billed charges are standardized to improve comparability. This involves adjusting charges to remove differences associated with variations in local market prices for inputs and those related to the size and intensity of hospitals' resident training activities.

15 A hospital may request geographic reclassification to a nearby market area for the standardized payment amount, the wage index (and capital geographic adjustment factor), or both. To qualify, a hospital must demonstrate that its wages are above average for its market area (above 106 percent for rural hospitals and 108 percent for urban hospitals) and comparable to the average in the area to which it seeks reclassification (at least 82 percent for rural hospitals and 84 percent for urban hospitals).

cost or revenue pressures.[16] Medicare also makes special payments to several groups of hospitals.[17] Most of these special payment provisions are designed to help rural hospitals, although some urban facilities also may qualify (MedPAC 2001b).

Indirect medical education payments Teaching hospitals receive add-on payments to reflect the additional (indirect) costs of patient care associated with operating approved physician training programs. The size of the indirect medical education (IME) adjustment applied to DRG payments depends on the hospital's teaching intensity, as measured by the number of residents per bed. In 2001, approximately 1,100 hospitals received IME payments; nearly 95 percent of those facilities were located in urban areas, although they served Medicare beneficiaries living in both urban and rural areas.

Disproportionate share payments Hospitals that treat a disproportionate share (DSH) of low-income patients receive additional payments that are intended to partially offset their revenue losses from furnishing uncompensated care. The DSH adjustment is based on nine different formulas and depends on urban or rural location, number of acute care beds, and other characteristics. The amount of the adjustment—the percentage from the applicable formula multiplied by the hospital's total DRG payments—depends on the hospital's low-income patient share. A hospital's low-income patient share is the sum of the proportion of its Medicare inpatient days furnished to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. No DSH payments are made unless a hospital's low-income patient share exceeds 15 percent.

Until 2001, small urban hospitals—those with fewer than 100 beds—and rural providers had to meet substantially higher minimum shares to qualify for DSH payments. In addition, those that qualified received DSH adjustments equal to 5 percent of DRG payments for small urban facilities and 4 percent for rural ones. Under these policies, DSH payments were highly concentrated in urban hospitals; more than 1,400 of the 1,800 DSH recipients were urban providers. The BIPA reduced the qualifying thresholds for small urban and rural providers to the same level applied for larger urban hospitals, and capped their DSH adjustments at 5.25 percent. (Urban hospitals with more than 100 beds do not have a maximum adjustment.) In 2001, these policy changes expanded eligibility for DSH payments from about 1,700 hospitals to about 2,800 hospitals; about 800 of the newly eligible facilities were in rural areas.

Outlier payments In general, hospitals are expected to offset losses on some cases (in which costs exceed the payment rate) with gains on others (in which costs are below payments). Some cases, however, are extraordinarily costly, producing losses that may be too large to offset. Hospitals facing fixed payment rates have strong financial incentives to avoid patients who may be likely to require extraordinary care. To ensure that seriously ill beneficiaries continue to have access to high-quality inpatient care, Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital DRG payments. Outlier cases are identified by comparing their costs to a DRG-specific threshold that reflects the DRG payment for the case (both operating and capital) plus a fixed loss amount. For instance, in 2002 the threshold is set at the DRG payment plus $21,025—the national fixed loss amount—adjusted to reflect input price levels in the local market. Medicare pays 80 percent of hospitals' costs above their fixed loss thresholds. IME and DSH adjustments are not applied to outlier payments. Outlier payments are funded by offsetting reductions in the operating base payment amounts (5.1 percent) and the capital federal rate (6.2 percent).

Transfer policy Medicare can reduce DRG payments when the patient is transferred to another PPS hospital, or in some instances to a post-acute care setting. When a patient is transferred to another PPS hospital, the transferring facility is paid a per diem amount for each day before the transfer occurs, up to a maximum of the full DRG payment.[18] The hospital receiving a transferred patient assigns a new DRG, which may or may not be the same as the DRG assigned in the previous hospital stay. Payment is according to the receiving hospital's assigned DRG as if the case had not been transferred.[19] Beginning in fiscal year 1999, discharges in 10 DRGs are treated as transfers if patients are sent to a long-term care hospital or a rehabilitation, psychiatric, or skilled nursing facility, or they receive clinically related home health care. This policy is intended to strengthen the boundaries of the hospital inpatient service bundle by reducing providers' financial incentives to unbundle services normally furnished during the latter part of a hospital inpatient stay. The 10 affected DRGs were selected by the Secretary of HHS based on their high volume and disproportionately high likelihood of post-acute care use. The

16 Medicare also reimburses acute-care hospitals for bad debts resulting from beneficiaries' nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts. The BBA reduced these payments, but the BIPA added some back. As a result, Medicare paid 70 percent of allowable bad debts in FY 2000.

17 These special payment provisions are discussed in greater detail in MedPAC's June 2001 Report to the Congress.

18 The per diem rate is the hospital's DRG payment rate divided by the national average length of stay for the same DRG. The hospital receives twice the per diem rate for the first day and the per diem rate for each additional day up to the full DRG rate. The hospital may also receive outlier payments calculated using a loss threshold prorated to reflect the length of stay.

19 If the patient is discharged to another PPS hospital, the transfer payment rules again apply.

Secretary was authorized to expand the set of DRGs to which this policy applies beginning in fiscal year 2001, but has not yet done so.

Payment updates Both the operating and capital payment rates are updated annually. The operating update is set by the Congress in law; the annual capital update is determined by the Secretary of HHS. In making recommendations regarding the annual updates, the Commission and CMS use update frameworks that take into account projected changes in input prices, science and technology, productivity, and other factors that are expected to affect efficient hospitals' costs (see Chapter 2).

Recommended and statutory updates for the operating and capital payment rates are generally expressed relative to the projected increase in the hospital MB index, which measures changes in national average prices for inputs hospitals purchase to produce services. An update usually would be expressed then as being equal to MB or MB minus 0.5 percentage points, for example.

Issues

Medicare's payment policies under the inpatient PPS raise three persistent and related questions:

1. Are Medicare's aggregate payments for acute care inpatient services adequate to ensure beneficiaries' access to high quality care without imposing unwarranted burdens on beneficiaries and taxpayers?

2. Do the various rate adjustments fully account for factors that should affect efficient providers' costs, thereby generating accurate payment rates for providers facing different circumstances?

3. Given the various limitations of the payment adjustments, is it ever desirable to exclude groups of providers from the PPS, and if, so when?

In 2000 and 2001, MedPAC recommended a number of actions to address these questions.

Improving clarity in assessing whether PPS payments are adequate to cover efficient providers' costs. Medicare makes extra payments to hospitals that serve low-income patients (DSH payments) and those that teach residents (IME payments). These payments are largely unrelated to hospitals' costs for serving beneficiaries—DSH payments reflect revenue losses associated with furnishing uncompensated care and about one-half of IME payments exceed the estimated effect of teaching intensity on Medicare costs per case (see Chapter 2). These payments are intended to support activities other than furnishing care to beneficiaries and they are concentrated among urban hospitals. Thus, we would be double-counting these payments if we included them in assessing whether Medicare's payment rates are adequate to cover efficient hospitals' costs of furnishing beneficiaries' care—they cannot be both funding other activities and paying for services for Medicare beneficiaries.

Improving accuracy in the payment adjustment for market input prices. The wage index may not accurately capture the market conditions faced by some hospitals. The labor market areas used to determine the wage index—especially in statewide rural areas—are frequently too large to reflect local market conditions. Other wage index issues include deciding which proportions of the payment rates are labor-related and should be adjusted by the wage index, and establishing the extent to which differences in the occupational mix of hospital employment may distort the measured market wage level. In 2001, we recommended evaluating the proportion of providers' payments adjusted by the wage index, and fully phasing out wages for teaching physicians, residents, and certified registered nurse anesthetists be fully phased out from the wage index to ameliorate inaccuracies resulting from variations among markets in the average occupational mix of hospital employment (MedPAC 2001b).

Addressing limitations in the payment adjustment for providers serving low-income patients. DSH adjustments for rural and small urban hospitals are currently capped at 5.25 percent, while those for large urban hospitals have no cap. We recommended major reforms that would be consistent for all hospitals (MedPAC 2001b, MedPAC 2000). Until those reforms can be implemented, however, we recommended increasing the cap on DSH adjustments for rural and small urban hospitals to 10 percent (MedPAC 2001b).

Improving Medicare's inpatient case-mix measurement methods to more accurately reflect the relationship between illness severity and the cost of inpatient care. The current DRG definitions and relative weights, and the current method of financing extra payments for high-cost outlier cases do not fully account for differences in illness severity associated with substantial disparities in providers' costs. To address this problem, we recommended that the Secretary improve payment accuracy by adopting DRG refinements that more fully capture differences in severity of illness and by basing the DRG relative weights on the national average of hospitals' relative values in each DRG. We also recommended that the Congress amend the law to change the method for financing outlier payments, using DRG-specific offsetting adjustments to the DRG relative weights rather than the current flat adjustment to the national average base payment amount (MedPAC 2000).

Addressing the higher unit costs of care in low-volume hospitals. Other things being equal, low-volume hospitals must spread their fixed costs over smaller numbers of cases, thereby raising their costs per discharge compared with facilities that treat larger numbers of patients. Our research (MedPAC 2001b) confirmed this relationship; hospitals with fewer than 500 total discharges per year had higher per-unit costs than hospitals with greater volume. We recommended that the Congress enact a graduated adjustment to the PPS payment rates for certain hospitals that experience low volume.

Avoiding harm from payment inaccuracies. When refinements are not available to address inadequacies in the PPS, excluding certain hospitals with similar characteristics may maintain the integrity and manageability of the inpatient PPS. The eligibility criteria for exemption, however, should target hospitals appropriately by identifying those with cost-raising conditions not accounted for in the PPS (MedPAC 2001b).

Payment for specialty psychiatric facilities

Medicare beneficiaries with mental illnesses or alcohol and drug-related problems are frequently treated in specialty psychiatric facilities, either freestanding hospitals or specialized hospital-based units. (People often group psychiatric facilities with post-acute care providers, perhaps because many of their patients have chronic conditions. Nevertheless, they generally furnish short-term acute care.) To be admitted to a specialty facility, patients generally have to be considered a risk to themselves or others.[20] Payments to psychiatric facilities (almost $3 billion in 2000) represent only a small part of total Medicare spending (about 1 percent), but the program accounts for about 30 percent of psychiatric facilities' revenue.

Psychiatric facilities are paid for furnishing care to Medicare beneficiaries under cost growth limits established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); payments are based on their incurred average operating costs per discharge, subject to an annually adjusted facility-specific limit (see text box, p. 16). Similar to their liability for stays in short-term acute care hospitals, beneficiaries treated in specialty psychiatric facilities are responsible for a deductible—$812 in 2002—for the first admission during a spell of illness, and for a copayment—$203 per day—for the 61st through 90th days. Beneficiaries treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness, with a 60-day lifetime reserve.[21] Over their lifetimes, however, beneficiaries are limited to 190 days of treatment in freestanding psychiatric hospitals.

The Congress required CMS to develop and implement a per diem PPS beginning on October 1, 2002.

Issues

CMS is developing a new PPS for beneficiaries' care in specialty psychiatric facilities. The design of the payment system is the principal emerging issue and will require the attention of policymakers in future years.

Designing the prospective payment system. The main issues are whether the PPS design will succeed in:

- distinguishing types of patient days that represent different bundles of clinical services with distinct resource costs,
- generating payments that are adequate to cover efficient providers' costs, and
- appropriately distributing those payments among treatment categories, markets, and other provider or patient characteristics.

A related issue is whether data to operate the payment system and monitor quality can be collected accurately and efficiently.

Ambulatory care

Medicare beneficiaries receive ambulatory care services from a variety of practitioners in several settings. The most common ambulatory services are:

- physician services,
- outpatient hospital care,
- ambulatory surgical care, and
- outpatient laboratory services.

These physicians and providers furnish a wide range of services, including some that are common to more than one setting. For example, beneficiaries may receive identical services in physicians' offices and hospital outpatient departments. Outpatient laboratory services help physicians in offices and outpatient departments to diagnose, treat, and monitor patients' illnesses or conditions. Some ambulatory surgeries can be performed in physicians' offices, outpatient departments, or ambulatory surgical centers. This section discusses how Medicare pays for the services delivered in these settings and summarizes issues of concern.

Payment for physician services

Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. These services are furnished in all settings, including physicians' offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes.[22] Medicare payments to physicians (about $49 billion in 2000) account for about 20 percent of total spending.

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

21 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$406 per day in 2002.

22 In general, Medicare makes separate payments for facility and professional services. Facility services may include room, board, routine and special care, and ancillary services (imaging, for instance) furnished in hospitals or other facilities. Professional services include procedures and evaluation and management services furnished by physicians and certain nonphysician professionals, such as physician assistants, nurse practitioners, and therapists.

Payment for facilities exempt from the prospective payment system for acute care hospitals

From Medicare's inception until 1983, all hospitals were paid based on their Medicare-allowable incurred costs. In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress set facility-specific limits on hospitals' operating costs per discharge, with penalties and rewards based on whether their costs were above or below the facility-specific limit or target. In 1984, short-term general acute care hospitals became subject to the inpatient prospective payment system (PPS), but other classes of facilities were exempt because the types of cases they treated and the relationships between case characteristics and efficient providers' costs were not well understood.

Five classes of specialty facilities were paid under TEFRA between 1983 and 2002—cancer hospitals, children's hospitals, long-term care hospitals, and rehabilitation and psychiatric facilities (including specialty hospitals and specialty units of general hospitals). From 1983 to 1998, each provider was paid an operating amount for each discharge, equal to the lesser of its current operating costs or a facility-specific target amount. The facility-specific target amount (limit) for each provider was based on its operating costs per discharge during its base year, updated for inflation using a TEFRA market basket index which measures changes in the prices of goods and services that specialty facilities must buy to produce inpatient care. Specialty facilities were paid for capital costs based on their Medicare-allowable incurred expenses until 1998, when the Congress reduced this capital pass-through to 85 percent of allowable costs.

Because facilities' operating targets were based on their own historical costs, TEFRA payments often varied substantially among facilities. In addition, new providers often entered the Medicare program with higher costs than older providers had, giving new providers higher targets and creating payment inequities.

To reduce these inequities, the Balanced Budget Act of 1997 (BBA) established national target caps beginning in 1998 for three provider groups: long-term care hospitals and rehabilitation and psychiatric facilities. (Cancer and children's hospitals continue to be paid under the old TEFRA method.) Operating payments for these providers are now determined by the lowest of three amounts:

- their current operating costs,
- their own updated target, or
- the national cap, adjusted to reflect the level of input prices in their local markets. The national per discharge cap in each provider group is the 75th percentile of the facility-specific targets for that group in 1996, updated for inflation. The national cap amounts are adjusted to each local market by multiplying the labor-related portion—72 percent in fiscal year 2002—by a version of the acute care hospital wage index, and adding the nonlabor cap amount (28 percent) to the result.

National target caps are updated for inflation using the TEFRA market basket index (see below). Facility-specific target amounts are updated annually by a variable percentage increase that depends on whether a facility's costs were above or below its target in the previous year and the size of the difference. This update policy was designed to help reduce differences among facilities' targets.

The Congress recently required the Centers for Medicare and Medicaid Services to design PPSs for these facilities. Long-term care hospitals and specialty psychiatric facilities will continue to be paid under current rules until the new PPSs are implemented. Rehabilitation hospitals will be paid a blend of the TEFRA amount and the PPS rates until the beginning of their fiscal year 2003 cost-reporting periods unless they choose to receive the full federal rate immediately. ■

National target caps for psychiatric facilities, rehabilitation facilities, and long-term care hospitals, fiscal year 2002

Facility class	Labor-related share	Nonlabor share	Total target cap
Psychiatric hospitals and units	$8,429	$3,351	$11,780
Rehabilitation hospitals and units	15,736	6,256	21,992
Long-term care hospitals	31,490	12,519	44,009

The Medicare physician payment system, implemented in 1992, is a mature system. To make predetermined payments for physician services, Medicare uses a fee schedule with payment rates for more than 7,000 services. Many services have two payment rates—a higher rate for services provided in non-facility settings, such as physicians' offices, and a lower rate for those furnished in facilities, such as hospitals. Rates are lower for services furnished in facilities because physicians' practice costs are generally lower; the facilities furnish some of the services that physicians normally would supply in the office setting and are paid separately.

Each service has a weight—called a relative value unit—that measures the relative costliness of three types of resources used to provide physician services: physician work, practice expenses, and expenses for professional liability insurance (PLI). Payment rates for services in each local market are determined by adjusting each relative weight to reflect the input-price level in that market, and then multiplying the total of the adjusted weights by a dollar amount called the fee schedule's conversion factor. Payment rates for physicians' services are adjusted further when they are:

- furnished by practitioners other than physicians,
- furnished in Health Professional Shortage Areas (HPSAs),
- provided by a physician who has not agreed to accept Medicare's payment rate as payment in full, or
- atypical (for example, the service is assisting the primary surgeon rather than serving as the primary surgeon performing a surgical procedure).

Payments are updated every year according to a formula called the sustainable growth rate (SGR) system, which is intended to keep spending growth consistent with growth in the national economy (see Chapter 2).

The physician fee schedule was adopted more than 10 years ago, but efforts to improve it continue. For example, CMS is working with the physician community to refine the relative weights for practice expenses. Other issues require the attention of the Congress. The SGR system does not adequately account for changes in the cost of providing physician services, a limitation that could jeopardize beneficiaries' access to care. In addition, some have raised questions about the adequacy of payment rates for services provided by some nonphysician practitioners.

Defining the physician services that Medicare buys

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

Setting payment rates

Under the fee schedule, payment rates are calculated by adding three relative weights and multiplying the sum by the conversion factor. The weights account for the relative costliness of the inputs used to provide physician services: physician work, practice expenses, and PLI expenses. The relative weights for physician work are based on physicians' assessments of the relative levels of time, effort, skill, and stress associated with each service. The relative weights for practice expense are based on the expenses physicians incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. The PLI relative weights are based on the premiums physicians pay for professional liability insurance.

In calculating payment rates, each of the three relative weights is adjusted to reflect the price level for related inputs in the local market where the service is furnished. Three geographic practice cost indexes are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by the fee schedule conversion factor.

Payments under the physician fee schedule also may be adjusted to reflect other factors. First, payments are decreased if services are furnished by certain nonphysician practitioners. Services provided by physician assistants and nurse practitioners are paid at 85 percent of physicians' fees and nurse midwives' services are paid at 65 percent.

Second, payments are adjusted according to so-called payment modifiers that appear on claims for payment to show whether the service provided was atypical. For example, physicians use a modifier to bill for a service when they serve as assistant surgeons. Payment for an assistant surgeon is 16 percent of the fee schedule amount for a surgical procedure. Other modifiers apply to multiple surgical procedures performed for the same patient on the same day, preoperative or postoperative management without surgical care, and bilateral surgery.

Third, under the Medicare incentive payment program, physicians receive bonus payments when they provide services in HPSAs. These payments are intended to attract more physicians to HPSAs. The bonus increases payments to these physicians by 10 percent (excluding beneficiary coinsurance).

Fourth, payments are adjusted downward when services are furnished by physicians who are not in Medicare's participating physician and supplier program (see text box, p. 18). Payment rates for services provided by non-participating physicians are 95 percent of the fee schedule's payment rate.

The fee schedule's relative weights are updated at least every five years; HCPCS codes and the conversion factor are

The participating physician and supplier program

Under the participating physician and supplier (PAR) program, physicians agree to accept the fee schedule's payment rate for a service as payment in full. In return, the program payment for the service is sent to the physician and not to the beneficiary. Also, the names of PAR physicians appear in a directory of participating physicians, available at Social Security offices and other locations. A non-PAR physician must bill the beneficiary for the program payment, unless the beneficiary assigns to the physician the right to receive the payment. Although non-PAR physicians bear the administrative costs and possible bad debt losses associated with billing beneficiaries for the program payment (and the related 20 percent coinsurance), they can also "balance bill" for a portion of the difference between Medicare's payment rate and the physician's usual fee. Balance billing, however, is limited to 15 percent of the payment for non-participating physicians. ■

updated annually. The update of relative weights includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In completing its review, CMS receives advice from a group of physicians and other professionals sponsored by the American Medical Association and physician specialty societies.

The annual updates for the conversion factor are made according to the SGR system, a formula intended to keep spending consistent with a target based on growth in the national economy. If actual spending is less than the target, the update is greater than the change in input prices for physician services. If actual spending is greater than the target, the update is less than the change in input prices.

Issues

Two issues are important in the physician fee schedule. Both concern the adequacy of payments.

Updating the conversion factor. Updates under the SGR system can lead to payments that diverge from costs because actual spending is unlikely to be the same as the system's target. Thus, payments are likely to be either too high, making spending higher than necessary, or too low, potentially jeopardizing beneficiaries' access to care (see Chapter 2).

Paying for services furnished by nonphysician practitioners. Payment rates are lower for services provided by nurse midwives than they are for services furnished by physician assistants and nurse practitioners. This difference in payment rates is not based on an analysis of training costs or other factors that might affect efficient practitioners' costs of furnishing care. This raises the question of whether current payment rates are appropriate for the services provided by these practitioners. The Congress has directed MedPAC to study this issue and report later this year.

Payment for outpatient hospital care

Medicare beneficiaries receive a wide range of services in hospital outpatient departments, from injections to surgical procedures requiring general anesthesia. Spending for these services is growing rapidly, largely because of changes in technology and medical practice that have fostered new services and encouraged shifts in care from inpatient to ambulatory care settings. Outpatient hospital care accounted for about 7 percent of total Medicare spending in 2000, or about $17 billion.

Medicare originally paid hospitals for outpatient care based on their allowable incurred costs. The BBA almost completely eliminated such cost-based payment by requiring CMS to develop and adopt an outpatient PPS, which was implemented in August 2000.

In requiring the outpatient PPS, the Congress also reduced beneficiary copayments for outpatient hospital care. When the BBA was enacted, copayments accounted for about 50 percent of total Medicare payments to hospitals for outpatient care. Under the new payment system, beneficiaries' share of total payments will slowly decline.[23] MedPAC has recommended that the Congress accelerate the reduction in these copayments (MedPAC 2001c).

Like the payment system for physician services, the new outpatient PPS is a fee schedule. It sets payment rates for individual services based on a set of relative weights, a conversion factor, and an adjustment for geographic differences in input prices. The PPS also includes an outlier adjustment for extraordinarily high-cost services and so-called pass-through payments for certain new technologies that are used as inputs in the delivery of services.

Because of uncertainty about the effects of the new system, certain types of hospitals are at least partially protected from financial losses. Cancer and children's hospitals are permanently held harmless from losses; small rural hospitals are held harmless through 2003 (MedPAC 2001a). Other hospitals that experience losses are eligible for partially offsetting payment adjustments through 2003.

Defining the outpatient hospital products that Medicare buys

Medicare pays for outpatient services based on the individual service or procedure provided, as identified by a

23 Under BIPA provisions, beneficiaries' shares of outpatient payments will be limited to no more than 40 percent by 2006; copayments of 20 percent for all services, however, will not be achieved for decades.

HCPCS code. CMS classified procedures, evaluation and management services, drugs and devices furnished in outpatient departments into about 750 ambulatory payment classifications (APCs). These APCs group items and services that are clinically similar and use comparable amounts of resources. More than 300 of the APCs identify drugs or devices used in conjunction with a procedure. In addition, some new services are assigned to certain "new technology" APCs based only on similarity of resource use. CMS chose to establish new technology APCs because some services were too new to be represented in the data used to develop the outpatient PPS. Services will remain in these APCs for two to three years while CMS collects the clinical and cost data necessary to refine and update the APC classification system.

Within each APC, CMS bundles integral services and items with the primary service. For example, the bundle for a surgical procedure includes operating and recovery room services, most pharmaceuticals, anesthesia, and surgical and medical supplies. In deciding which services to bundle and which to pay separately, CMS considered comments from hospitals, hospital suppliers, and others. For example, in response to public comments, CMS separated corneal tissue acquisition, maintenance, and distribution from services requiring corneal tissue. CMS also pays separately for blood, blood products, and plasma-based and recombinant therapies.

Unlike all other services included in the outpatient PPS—for which the unit of payment is the service or procedure provided—partial hospitalizations for psychiatric services are paid on a per diem basis. These intensive outpatient psychiatric services may be provided by a hospital outpatient department or by a community mental health center, and the per diem payment rate represents the expected facility costs for a day of care.

Setting product payment rates

Payment rates in the outpatient PPS are intended to cover hospitals' operating and capital costs for the facility services they furnish; professional services (physicians' services provided to individual patients, for example) are paid separately. Outpatient payment rates are determined by multiplying the relative weight for an APC by a conversion factor. Except for the new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. Services are assigned to a new technology APC based on their expected cost. New technology APCs start at $0 to $50 and end at $5,000 to $6,000; the relative weights are set at the midpoint of these ranges.

The conversion factor translates the relative weights into dollar payment amounts. The initial conversion factor was set so that projected total payments—including beneficiaries' copayments—would equal the estimated amount that would have been spent under the old payment methods, after correcting for some anomalies in statutory formulas.

To account for geographic differences in input prices, the labor portion of the conversion factor (60 percent) is adjusted by the hospital wage index.

The outpatient PPS includes four additional payment adjustments: pass-through payments for new technology; outlier payments for high-cost services; hold-harmless payments for cancer, children's and small rural hospitals; and transitional corridor payments that help to limit hospitals' financial losses under the PPS.

In addition to the new technology APCs, the pass-through payments are a second way that the outpatient PPS accounts for new technologies. Unlike the new technology APCs, however, pass-through payments are not payments for individual services. Instead, they are payments for certain new technology items—drugs, biologicals, and devices—that are used in the delivery of services. By supplementing the payments for individual services, pass-through payments are meant to help ensure beneficiaries' access to new technologies that were not well represented in the 1996 data that CMS used to set the PPS payment rates. For drugs and biologicals, the payments are based on average wholesale prices. For devices, the payments are based on each hospital's costs (as determined by adjusting its charges using a cost-to-charge ratio). By law, total pass-through payments are limited to 2.5 percent of total payments under the outpatient PPS, and the conversion factor is reduced by 2.5 percent to finance them. If CMS projects that pass-through payments will exceed this limit during a year, the agency is required to reduce all pass-through payments in that year by a uniform percentage to meet the limit. However, CMS did not maintain budget neutrality in 2000 or 2001, and has not so far in 2002 (see Chapter 3).

Outlier payments are made for individual services or procedures with extraordinarily high costs, compared with the payment rates for their APC group. Outliers are defined by the BBRA as services with costs that exceed a threshold equal to three times the PPS payment rate. Hospitals will be reimbursed for 50 percent of the difference between the threshold and the cost of the service in 2002. Aggregate outlier payments are limited to 2 percent of total payments; outlier payments are financed by reducing the conversion factor by 2 percent.

The BBRA mandated that cancer hospitals and outpatient departments of small rural hospitals (100 or fewer beds) be held harmless from financial losses under the PPS. This protection is permanent for cancer hospitals; small rural hospitals are protected until 2003. In addition, the BIPA extended permanent hold-harmless protection to children's hospitals. These hospitals will be paid according to the PPS payment rates. If their PPS payments are lower than those they would have received under previous policies, however, they will receive extra payments to make up the difference.

To smooth the way to the outpatient PPS, the Congress mandated transitional corridor payments in the BBRA that will continue through 2003. The amount of

these payments depends on the difference between a hospital's PPS payments and what it would have received under the previous payment policy. Corridor payments are intended to make up a high proportion of hospitals' small losses, but a declining proportion of larger losses. For example, in 2000 and 2001, corridor payments made up 80 percent of losses that were less than 10 percent of what the hospital would have received under previous policy, but only 70 percent of losses in the 10 to 20 percent range. In 2002 and 2003, the transitional corridor payments will make up declining proportions of hospitals' revenue losses under the PPS.

The APC groups and their relative weights are reviewed and revised annually. The review considers changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information. CMS is required to consult with a panel of experts as part of this review.

CMS also annually updates the conversion factor by the hospital market basket index. For 2002, the BBA reduced this update by 1 percentage point.

Issues

Three emerging issues are important in payment policy for outpatient hospital care.

Limiting the pass-through payments for new technologies. The pass-through payments are projected to exceed their statutory limit in 2002. This raises the question of whether and how the Congress or CMS should either reduce the payment rates for pass-through items or restrict the number of eligible items (see Chapter 3).

Protecting cancer, children's, and small rural hospitals from financial losses. The hold-harmless payments for small rural hospitals will end in 2003; hold-harmless payments for cancer and children's hospitals are permanent. The Congress enacted these payments in response to impact projections (prepared by CMS when it first proposed the outpatient PPS), which suggested that these hospital groups would experience large payment reductions under the new payment system. At issue is whether hospitals' actual experience differs substantially from the initial projections, making changes to these provisions necessary.

Updating the conversion factor. Multiple factors affect the cost of providing outpatient hospital care, including changes in input prices, scientific and technological advances, and changes in complexity within services. In many instances, payment updates equal to the projected change in the hospital MB index would be sufficient to ensure adequate payment levels for hospital outpatient care. Policymakers need to be aware, however, that the effects of other factors may sometimes make such updates either too large or too small.

Payment for care provided by ambulatory surgical centers

Since 1982, Medicare has covered surgical procedures provided in free-standing or hospital-based ambulatory surgical centers (ASCs). ASCs are distinct facilities that furnish only outpatient surgery; the most common procedures are cataract removal, colonoscopy, and arthroscopy. Payments to ASCs (about $1 billion in 2000) account for 0.5 percent of total Medicare spending.

Medicare pays for surgery-related facility services provided in ASCs—such as operative nursing, recovery care, anesthetics, drugs, and other supplies—using a simple fee schedule. (Medicare pays for the related physician services—surgery and anesthesia—under the physician fee schedule.) The ASC fee schedule sets payment rates for only eight procedure groups. The payment rates are adjusted to reflect geographic differences in market input prices. Medicare revises the payment rates at five-year intervals based on a survey of ASCs' costs and charges. Between revisions, the rates are updated annually using the consumer price index for all urban consumers (CPI-U).

Defining the care that Medicare buys from ambulatory surgical centers

The unit of payment in the ASC payment system is the individual surgical procedure. ASCs assign HCPCS codes to about 2,300 procedures when they submit claims for payment. These codes, in turn, are classified into one of eight payment groups.

Approved procedures generally are limited to those that are provided in hospital inpatient settings that also can be performed safely in outpatient facilities. Procedures frequently performed in physicians' offices are specifically excluded from the ASC-approved list. ASC-approved procedures usually require less than 90 minutes of operating room time and less than 4 hours of recovery room time.

Setting product payment rates

To set ASC payment rates, CMS is required to survey a sample of ASCs every five years to collect data on their charges for individual procedures and their total costs and charges. After auditing the survey data, CMS adjusts ASCs' charges to reflect costs using their overall cost-to-charge ratios. Then, CMS sets the national payment rate for each payment group equal to the median cost for that group.

To account for geographic differences in market prices for inputs, the labor portion of ASC payment rates (34.45 percent) is adjusted by the hospital wage index. ASC payment rates also are adjusted when multiple surgical procedures are performed during the same operative session. In this case, the ASC receives full payment only for the procedure with the highest payment rate; payments for the other procedures are reduced to one-half of their usual rates.

Between rate surveys, the ASC payment rates are updated annually based on the CPI-U. The BBA limited those updates to the CPI-U minus 2 percentage points (but not less than zero) through fiscal year 2002. CMS also is required to update

every two years the list of procedures performed in ASCs that are eligible for Medicare payment.

Issues

Two issues are important in ASC payment policy:

Restructuring ASC payment rates. In 1998, CMS proposed to restructure ASC payment rates to make them more consistent with the outpatient PPS. The proposal was to replace the eight ASC payment groups with a classification of services according to APCs. CMS has not implemented this proposal because other priorities have intervened, including work on the outpatient PPS. Now that the outpatient PPS is in its second year, the question is whether CMS has the resources necessary to move ahead with restructuring ASC rates.[24]

Rebasing ASC payment rates. In 1998, CMS also proposed to rebase ASC payment rates using more current rate survey data. The current rates are based on a rate survey conducted in the late 1980s and thus are probably not consistent with ASC costs. In response to CMS's proposal, the Congress included a provision in the BIPA that requires CMS to use survey data from 1999 or later in rebasing ASC rates. As with restructuring the rates, the issue is whether the agency has the resources necessary to proceed with a new rate survey.

Payment for outpatient laboratory services

Clinical laboratory tests help physicians diagnose, treat, and monitor patients' illnesses and conditions. Beneficiaries may receive tests during a hospital stay or a visit to a physician's office or outpatient department. Medicare pays hospitals for tests furnished during a hospital stay as part of the bundled inpatient payment. In contrast, Medicare pays the labs directly based on a fee schedule for tests performed in an outpatient setting. Three main types of labs serve these ambulatory patients: hospital-based labs; independent labs which usually serve a region; and physician office labs which generally perform only relatively simple tests. Although Medicare payments account for about 30 percent of laboratories' revenues, laboratory payments account for about 2 percent of total Medicare spending.

Medicare uses a simple PPS (fee schedule) established in 1984. Payment rates were initially set separately for more than 1,100 tests in each carrier's geographic market, based on what local labs charged in 1983; since then, the rates have been updated periodically for inflation.[25] PPS payment rates are also limited by national service-specific maximums that affect almost all lab claims.

Defining the laboratory products Medicare buys

Medicare sets payment rates for more than 1,100 HCPCS codes used in billing for laboratory services. Although in theory there is a separate code for each service, in practice a single HCPCS code may identify more than one testing method for a given substance or more than one substance analyzed by a single method. Panel tests, which are tests commonly ordered together, have their own HCPCS codes as well.

Setting product payment rates

The fee schedule payment rates represent the total payment laboratories will receive for their services; beneficiary copayments are not required. CMS assigns payment amounts for all lab HCPCS codes in each carrier market based upon 1983 charges from the laboratories in that market. Medicare payments were set at the 60th percentile of prevailing charges for freestanding laboratories and the 62nd percentile for hospital-based laboratories in each area. In 1987, fees for outpatient services in hospital laboratories, other than those performed in sole community hospitals, were reduced to the 60th percentile of prevailing charges. Fee schedule amounts differ from carrier to carrier in some instances, but no separate geographic adjustment is provided.

Beginning in 1986, the Congress established upper limits on laboratory payment rates, called national limitation amounts (NLAs). NLAs are based on the median of all carrier rates for each test. The NLAs have been repeatedly reduced and currently are set at 74 percent of the median of all local fee schedule amounts for each procedure. Because so many of the carrier payment rates are constrained by the NLAs, most lab services are paid the same national rate.

When newly developed tests are used by laboratories, CMS either assigns payment rates based on their similarity to existing tests or requires carriers to independently set the rates for the first year of use. Carriers must research and set their own payment amounts. They may obtain cost data from manufacturers, payment data from other carriers, or perform their own analyses.

Issues

Although no evidence exists that beneficiaries' access to laboratory services has been compromised, policymakers should address two problems in laboratory payment policy.

Improving the relationship of payment rates to costs. Unlike other PPSs, the lab fee schedules are based only on 20-year old charges. The carriers did not adjust those charges to costs when originally creating their fee schedules, so it is unlikely that the fee schedules were ever consistent with the efficient costs of providing laboratory services. The

24 In commenting on the ASC proposed rule, MedPAC raised two concerns. First, the large variations in costs among services in some APCs made us worry that some ASCs might respond inappropriately to financial incentives, increasing service volume for low-cost procedures while avoiding those with relatively high costs. Second, the APCs for ASCs were not fully consistent with those then being considered for outpatient hospital care. We took these positions before CMS implemented the outpatient PPS based on substantially revised APC definitions. Thus, we may not have the same concerns if CMS were to adopt the outpatient APCs in a restructured ASC payment system.

25 Carriers are CMS contractors who are responsible for reviewing and paying providers' Medicare Part B claims.

passage of time has probably made this problem worse because factors other than inflation, such as technological innovation, have affected laboratory costs since 1983.

Streamlining fee schedule development and claims processing. Having a separate fee schedule for each carrier region is a waste of resources. Similarly, different standards among carriers for documenting the medical necessity of tests have contributed to an average claims denial rate of 15 percent, with much higher rates for certain tests in some areas. To reduce this redundancy and confusion, the BBA required CMS to consolidate its contractor functions for laboratories into five or fewer regional laboratory carriers. The agency has deferred responding to this mandate largely because of resource constraints.

Post-acute care

Many Medicare beneficiaries receive post-acute care from one of four types of providers:

- skilled nursing facilities,
- home health agencies,
- inpatient rehabilitation facilities, and
- long-term care hospitals.

Most patients use this care immediately following an acute hospital stay. This section discusses how Medicare pays for these services and issues that require attention in each of these settings.

Payment for skilled nursing facility services

Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing facilities (SNFs).[26] SNFs can be hospital-based units or freestanding facilities.[27] About 1.4 million beneficiaries use SNF care in a year, but Medicare's payments for these services account for only about 10 percent of freestanding nursing facilities' revenues; they make up less than 2 percent of hospitals' revenues. Similarly, payments to SNFs ($13 billion in 2000) represent only about 5 percent of total Medicare spending.

Medicare adopted a new PPS for SNF services on July 1, 1998. Throughout most of the 1980s and 1990s, however, SNFs were paid on the basis of their costs, subject to limits on their per diem routine costs (room, board, and routine nursing care); no limits were applied for ancillary services (such as drugs and therapy). Under the PPS, SNFs are paid a predetermined rate for each day of care. The per diem rates are based primarily on the patient's service needs and market conditions in the facility's location. Patients are assigned to 44 groups, each containing patients with similar service needs that are expected to require similar amounts of resources. The daily rate for each group is the sum of three components:

- a fixed amount for routine services (such as room and board, linens, and administrative services);
- a variable amount reflecting the intensity of nursing care patients are expected to require; and
- a variable amount for the expected intensity of therapy services.

The rates are computed separately for urban and rural areas and a portion of the total rate is adjusted to reflect market conditions in each SNF's location.

The SNF PPS has problems characterizing and classifying patient days, thereby raising questions about its ability to generate payments that accurately reflect efficient providers' costs of furnishing care. Partly in response to this problem, the Congress temporarily increased payments to SNFs. Two of the three payment increases are scheduled to expire at the end of fiscal year 2002, prompting concern that the resulting payment reductions might adversely affect beneficiaries' access to high-quality care.

The skilled nursing facility product Medicare buys

Medicare sets daily payment rates for 44 resource utilization groups, version III (RUG-III), which are distinguished by patients' expected service needs. Patients' expected service needs are determined by periodic assessments of their condition, including their needs for intensive physical, occupational, or speech therapy; special treatments (such as tube feeding); and their functional status (their ability to manage unassisted ordinary daily activities, such as eating, bathing, and dressing).

Setting product payment rates

The PPS rates are expected to cover all operating and capital costs that efficient facilities would be expected to incur in furnishing covered SNF services. Each of the 44 RUG-III groups has a daily rate comprising a fixed routine amount plus a nursing component and a therapy component. The nursing component is calculated by multiplying a base rate for nursing by a national relative weight that reflects the intensity of nursing care that patients in each RUG-III category are expected to receive. For groups that require intensive therapy, the therapy component is calculated by multiplying a base rate for therapy by a national relative weight that reflects the expected intensity of therapy; a fixed rate is used for groups receiving routine therapy. Rates are set separately for urban and rural SNFs.

The rates are adjusted to account for differences in input prices among SNF markets. The labor-related portion of the daily payment rate—75 percent for fiscal year 2002—is multiplied by the hospital

26 Medicare covers 100 SNF days in a spell of illness. Medicare pays 100 percent of the rate for the first 20 days of a SNF stay. From the 21st to the 100th day, beneficiaries are responsible for a copayment equal to one-eighth of the hospital deductible, or $101.50 per day in 2002.

27 Freestanding SNFs are frequently part of a nursing facility that provides residential long-term care, which is not covered by Medicare.

wage index in the SNF's location and the result is added to the nonlabor portion.[28] Rates are updated annually, based on the projected increase in the SNF market basket index, a measure of the national average price level for the goods and services SNFs purchase to provide care.

The initial payment rates in 1998 were set to reflect the projected amount that SNFs received in 1995, updated for inflation.[29] The Congress subsequently increased the payment rates temporarily in several ways:

- the BBRA increased rates for all 44 RUG-III groups by 4 percent for care furnished from April 2000 through September 2002,
- the BIPA increased the base rate for the nursing component by 16.66 percent for care furnished from April 2001 through September 2002, and
- the BBRA and BIPA increased rates for 14 rehabilitation groups by 6.7 percent, and those for 12 complex care groups by 20 percent. These increases were intended to give CMS time to refine the RUG-III classification system and they expire when CMS adopts that refinement.

With these changes, the rates range from $141 to $515 per day (unadjusted for wage differences).

Issues

Three issues are important in SNF payment policy.

Replacing the classification system. The SNF patient assessment instrument does not collect certain information needed to characterize and classify the medically complex patients found in these facilities (MedPAC 2001c). In addition, the SNF payment rates do not cover the costs of so-called nontherapy ancillaries (such as drugs and respiratory therapy) needed to care for some SNF patients.[30] An attempt to refine the RUG-III failed in 2000. Therefore, in 2001, MedPAC recommended that a new classification be developed to better account for resources needed to care for SNF patients. CMS contract researchers are currently evaluating alternatives to the RUG-III classification system, as required by the BIPA.

Ensuring adequate payments. Two of the three temporary rate increases to SNF payments expire by the end of fiscal year 2002. Those intended to address limitations in the RUG-III classification system will remain. The temporary rate increases were designed to preserve beneficiaries' access to high quality SNF care. Our assessment of current SNF payment rates addresses the question of whether these rate increases may still be needed to protect beneficiaries (see Chapter 2).

Monitoring substitution of services among alternative settings, including hospital inpatient facilities, SNFs, home health agencies and other post-acute care settings. Patients hospitalized for specific conditions or procedures—strokes, broken hips, or joint replacements, for instance—might receive similar skilled care or rehabilitation services in any of several settings. The availability of multiple sites of care raises potential trade-offs for policymakers among access, cost, and quality of care. Moreover, shifts in service volume among settings could indicate that providers are shifting beneficiaries' care in response to financial incentives that reflect unwarranted disparities in payment rates; alternatively, such shifts could be benign. To ensure that beneficiaries have access to care in the most clinically appropriate setting while acting as prudent buyers, policymakers need to monitor shifts in the locus of care and consider care alternatives in developing payment policies for each setting.

Payment for home health care services

Beneficiaries who are generally confined to their homes and need skilled care (from a nurse, physical or speech therapist) on a part-time or intermittent basis are eligible to receive certain medical services at home. Covered services are delivered by home health agencies (HHAs) in visits to beneficiaries' homes, including:

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

Beneficiaries are not required to make any copayments for these services.

Almost 1 in 10 beneficiaries used home health care in 1999. Medicare's payments to HHAs were about $9 billion in 2000, accounting for 4 percent of total Medicare spending but a large share of HHAs' total revenues.

Until October 2000, HHAs generally were paid on the basis of their incurred average costs per visit subject to annually adjusted limits.[31] In October 2000, CMS adopted a new PPS in which HHAs are paid a predetermined rate for each 60-day episode of home health care. The payment rates are based on patients' conditions and service use, and they are adjusted to reflect the level of market input prices in

28 The wage index used to adjust SNF payments is based on labor compensation data reported by acute care hospitals and is not adjusted for the effects of hospitals' geographic reclassifications.

29 By law, this projection excluded costs of SNFs that were exempt from Medicare's routine cost limits or that had so-called atypical exceptions in 1995 and included only 50 percent of the difference between the average costs of hospital-based and freestanding facilities.

30 SNF rates include costs of nontherapy ancillaries (ancillaries other than physical, occupational, and speech therapy) only to the extent that they correlate with nursing staff time. As a result, the rates do not cover the costs of patients in some groups who require above average amounts of these services.

31 From 1997 to October 2000, HHAs were paid the least of three amounts: their average annual cost per visit by visit type subject to limits, their average annual cost per beneficiary, or their charges.

the geographical area where services are delivered. If fewer than 5 visits are delivered during a 60-day episode, the HHA is paid per visit by visit type, rather than by the episode payment method. Adjustments for several other special circumstances, such as high-cost outliers, can also modify the payment. Payment rates also are increased for patients in rural areas.

The primary challenge for this new PPS is to set payment rates that are adequate to ensure beneficiaries' access to appropriate home care services. Setting rates for Medicare home health services has always been complicated by the lack of a clear definition of the benefit. The benefit was originally intended for short-term, post-hospital recovery care for beneficiaries who could not leave their homes, but changes to eligibility criteria have expanded the benefit. Beneficiaries who have no preceding hospital stay and are capable of spending significant time outside their homes are now eligible to receive covered services furnished in an unlimited number of home care episodes. Consequently, paying for appropriate care while controlling spending and ensuring access is a continuing challenge.

The home health products Medicare buys

Medicare purchases home health services in units of 60-day episodes. For each episode of care, the payment amount is intended to cover what an efficient provider would have to spend in furnishing visits, supplies, outpatient therapy, and patient assessments. The severity of a patient's condition changes the expected amount of resources—chiefly the number and type of visits—required for high-quality care. To capture differences in expected resource use, patients receiving 5 or more visits are assigned to 1 of 80 home health resource groups (HHRGs) based on diagnosis, functional capacity, and service use.

Setting the rates

The HHRGs range from groups of relatively uncomplicated patients to those containing patients who have severe medical conditions, severe functional limitations, and need extensive therapy. Each HHRG has a national relative weight reflecting the average relative costliness of patients in that group compared with the average Medicare home health patient. The payment rates for HHRGs in each local market are determined by adjusting a national average base amount—the amount that would be paid for a typical home health patient residing in an average market—to reflect the input-price level in the local market and then multiplying the adjusted local amount by the relative weight for each HHRG.

The initial national average base payment amount for a typical home health episode is intended to reflect the projected amount providers would have received per episode under the previous payment system, updated for inflation. Because providers receive payments on a per-visit basis for patients who are furnished fewer than 5 visits in 60 days, the base amount was adjusted to reflect this policy. It was also reduced 5 percent to account for anticipated high-cost outlier payments. For fiscal year 2002, the national average payment rates for HHRGs range from $1,197 to $6,393.

To capture local market conditions, the per-episode payment rate is divided into labor and non-labor portions; the labor portion—77 percent—is adjusted by a version of the hospital wage index to account for geographic differences in the market prices for labor-related inputs to home health services.[32] For most services provided in facilities, the location of the facility determines the local area adjustment that applies. For home health services, however, the local area adjustment is determined by the beneficiary's residence. The total payment is the sum of the adjusted labor portion and the nonlabor portion.

Payment rates are temporarily increased by 10 percent for care delivered to beneficiaries who live in rural areas. This is intended to compensate for potentially higher visit costs in rural areas related to low patient volume and long distances between patients.

When a patient's episode of care involves an unusually large number or a costly mix of visits, the HHA may be eligible for an outlier payment. To be eligible, imputed episode costs must exceed the payment rate by 13 percent or more. Episode costs are imputed by multiplying the estimated national average per visit costs by type of visit—adjusted to reflect local input prices—by the numbers of visits by type during the episode. When these estimated costs exceed the outlier threshold, the HHA receives a payment equal to 80 percent of the difference in addition to the episode payment.

The base rate is updated annually. The update is based on the projected change in the home health market basket, which measures changes in the prices of goods and services home health agencies must buy to produce care. For fiscal years 2002 and 2003, the update is set by law at the projected increase in the MB index minus 1.1 percentage points.

Issues

Three issues are important in home health payment policy. Two of these concern whether payments are adequate to cover efficient providers' costs; any resolution will require the Congress' attention (see Chapter 2).

Addressing the so-called 15 percent cut, now scheduled to take effect in 2003. The BBA mandated a 15 percent reduction in Medicare payments for home health services in response to rapid growth and high levels of spending in the early 1990s. Under this policy, CMS would have to lower the PPS payment rates enough to reduce total home health spending to 15

32 The wage index used to adjust home health payments is calculated from wage data reported by acute care hospitals without the effects of geographic reclassifications.

percent below that projected under the previous per visit cost-based reimbursement system. Policymakers have postponed the reduction several times. At current spending levels, it is possible that the target spending level could be met by reducing the PPS payment rates by only about 6 percent. This raises the question of whether to continue to postpone the cut, eliminate it, or adopt it.

Is the rural add-on needed? Rural home health providers may face higher costs per episode because they have low service volume or they have to travel relatively long distances between clients. Neither of these factors is directly compensated in the PPS. Instead, the rural add-on increases payments for rural beneficiaries' home health services by 10 percent. However, it is not clear whether the add-on is needed, and if it is, whether it appropriately targets providers that have higher costs. We plan to further evaluate rural home health costs to address this issue.

Identifying the appropriate level of home health service use and monitoring that these services are delivered. One of the principal difficulties in setting payment rates for home health care is that policymakers do not know the appropriate level of service use. Development of clinical standards for home health care for common conditions might resolve at least some of the uncertainty. If so, policymakers need to provide resources and assign responsibility to carry out development and testing of clinical standards.

Payment for inpatient services in rehabilitation facilities

After an illness, injury, or surgical care, some patients need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. Relatively few beneficiaries use intensive rehabilitation therapy because they must be able to tolerate and benefit from three hours of therapy per day to be eligible for treatment in an inpatient rehabilitation setting. Among those who qualify, many are admitted to inpatient rehabilitation facilities (IRFs), which may be freestanding hospitals or specialized, hospital-based units. Others may receive care in a SNF, especially in markets that lack IRFs or have few rehabilitation beds. Although payments to IRFs (about $4 billion in 2000) represent only a small part of total Medicare spending (about 2 percent), Medicare accounts for a large share of IRF revenues.

Until January 1, 2002, Medicare paid IRFs (under TEFRA) on the basis of their incurred average costs per-discharge, subject to annually adjusted facility-specific limits (see text box, p. 16).[33] Beginning in January 2002, IRFs are paid predetermined per-discharge rates based primarily on the patient's condition (diagnoses, functional and cognitive statuses, and age) and market conditions in the facility's location.[34] Discharges are assigned to case-mix categories containing patients with similar clinical problems that are expected to require similar amounts of resources. Each case-mix category has a national relative weight reflecting the expected relative costliness of treatment for a patient in that category compared with that for the average Medicare inpatient rehabilitation patient. The payment rates for case-mix categories in each local market are determined by adjusting a national average base payment amount to reflect the input-price level in the local market, and then multiplying the adjusted local amount by the relative weight for each case-mix group. Payment rates also are increased for facilities located in rural areas and those that treat a disproportionate share of low-income patients.

Like all new payment systems, this one must be monitored to ensure it provides adequate payments while operating efficiently. Inadequate payments might affect beneficiaries' access to high quality care.

Defining the inpatient rehabilitation products Medicare buys

Under the inpatient rehabilitation PPS, Medicare sets payment rates for 385 intensive rehabilitation products—called case-mix groups (CMGs)—defined by types of treatment episodes. Patients are assigned to 380 of these treatment categories based on the primary reason for intensive rehabilitation care (for example, a stroke or burn); their age and levels of functional and cognitive impairments; and the types of comorbidities (co-existing conditions) present during the stay. The other five categories are for patients discharged before the fourth day—short-stay outliers—and for those few who die in a facility. Further, IRFs may receive only partial payment for other patients who do not receive a full course of intensive therapy because they are discharged to another facility and the length of stay is less than that typically provided to patients with the same condition.[35]

Setting product payment rates

The PPS payment rates are intended to cover all operating and capital costs that efficient facilities would be expected to incur in furnishing covered rehabilitation services. The initial payment level (base rate) for a typical discharge—$11,838 for fiscal year 2002—is intended to reflect the projected amount providers would have been expected to receive per discharge under the previous payment system

33 Patients transferred to inpatient rehabilitation from a short-term acute hospital—about 93 percent of patients—are not responsible for a deductible for the admission. Those admitted directly pay the same deductible ($812) and copayments as for an acute inpatient stay.

34 IRFs began receiving payments under the new PPS at the beginning of their 2002 cost reporting periods. During a one-year transition period, they are paid a blend of two-thirds the PPS rate and one-third their facility-specific TEFRA rate updated to fiscal year 2002.

35 For these patients, facilities are paid a per diem rate up to a maximum of the full rate for the treatment category.

(TEFRA) in 2002. Because providers will receive additional payments under the PPS for extraordinarily costly patients (high-cost outliers), the projected amount is reduced (3 percent) to maintain the same expected total spending. Further, reflecting its experience with similar financial incentives under other discharge-based PPSs, CMS decreased the base rate (by 1.16 percent) in the expectation that providers would lower their costs by reducing lengths of stay compared with those under TEFRA.

The base rate is adjusted to account for differences in input prices among markets. The labor-related portion of the base payment amount—72 percent—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion.[36] The adjusted rate for each market is multiplied by the relative weights for all CMGs to create local PPS payment rates.

Payment rates are increased for IRFs located in rural markets and for those that treat low-income patients. Rural facilities' payment rates are increased by 19 percent to compensate for their tendencies to have fewer cases, longer lengths of stay, and higher average costs per case. An IRF is eligible to receive higher payment rates if it serves at least one low-income patient. The payment adjustment for each facility is based on its low-income patient share, which is the sum of two proportions: the proportion of total inpatient days furnished to beneficiaries eligible for Supplemental Security Income benefits and the proportion of total patient days furnished to Medicaid patients.[37] After adjustments for local market conditions, rural location, and type of treatment category, the CMG payment rates range from $5,050 to $56,884 in the continental United States.

Finally, IRFs receive additional payments for high-cost outliers when their costs exceed a fixed-loss threshold. An IRF has a threshold for each CMG equal to its regular payment rate plus a national fixed-loss amount ($11,211) adjusted by the wage index for the IRF's market. For high-cost outliers, IRFs receive their regular payment rates plus 80 percent of their costs above the fixed-loss threshold.

Both the base rate and relative weights are updated annually. The base rate is updated using the TEFRA market basket index (used for facilities originally excluded from the acute care hospital PPS) expanded to reflect changes in the price of capital. The relative weights are updated based on changes in national average charges per discharge for each CMG.

Issues

Two issues are particularly important when a new payment system is implemented. The first is whether payments are adequate; the second is whether they are updated appropriately. Both need CMS's action.

Ensuring adequate payments. Like all new payment systems, this PPS will need to be monitored to determine whether the payment rates cover efficient providers' costs of furnishing rehabilitation care and whether the distribution of payments across treatment categories, markets, and other provider characteristics is adequate. In addition, some have questioned whether the current patient assessment instrument collects the right information. The reported information should be the minimum amount sufficient to operate the PPS and monitor quality.

Updating payments. The TEFRA market basket index is used to annually update inpatient rehabilitation facilities' payments. This market basket reflects changes in the prices of goods and services used to furnish care by the five types of hospitals exempted from the acute care hospital PPS in 1983 and may not accurately measure price changes for inputs used to provide intensive rehabilitation care.

Payment for services furnished in long-term care hospitals

Patients with clinically complex problems, such as multiple acute or chronic conditions, may need hospital care for relatively extended periods of time. Some are admitted to long-term care (LTC) hospitals.[38] Others—especially in the many markets without LTC hospitals—may be cared for in acute care hospitals or SNFs. Payments to LTC hospitals (almost $2 billion in 2000) represent only a small part of total Medicare spending (less than 1 percent); however, Medicare accounts for a substantial proportion of LTC hospitals' revenues.

LTC hospitals are paid for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, subject to an annually adjusted facility-specific limit (see text box, p. 16).[39] The Congress required CMS to implement a per-discharge PPS beginning October 1, 2002.

Issues

Two issues are important to payment policy for LTC hospital services and will require attention in the future. One is whether the new PPS will pay LTC hospitals adequately to preserve beneficiaries' access to this care. The other is whether Medicare is paying twice for patients in hospitals within hospitals (HWHs).

Implementing the prospective payment system. The principal issues are whether the PPS will appropriately characterize and classify patients, generate payments that are adequate to cover efficient

36 The wage index used to adjust IRF payments is calculated from wage data reported by acute care hospitals without the effects of geographic reclassifications.

37 The low-income patient share is different from the disproportionate patient share used in the acute care hospital inpatient PPS.

38 LTC hospitals are defined as hospitals with an average length of stay of 25 days or more.

39 Patients transferred to a long-term care hospital from a short-term acute hospital—about 80 percent of patients—are not responsible for a deductible for the admission. Those admitted directly pay the same deductible ($812) and copayments as for an acute inpatient stay.

providers' costs of furnishing long-term hospital care, and accurately reflect cost differences among treatment categories, markets, and other provider characteristics.

Growing numbers of hospitals within hospitals. The number of long-term care HWHs has increased rapidly since the mid-1990s. HWHs are LTC hospitals located in buildings of or on the campuses of acute-care hospitals. HWHs reportedly represented more than one-fourth of LTC hospitals in 1997 and more than three-fourths of HWHs were established after 1993. Acute-care hospitals with HWHs have strong financial incentives to discharge patients who have longer-than-average stays into the HWH. To the extent that hospitals acted on these incentives, Medicare would pay twice for one patient stay.

Services for special populations

Many Medicare beneficiaries have special needs resulting from end-stage renal disease (ESRD) or a terminal illness. These beneficiaries may receive services in two specialized settings:

- outpatient dialysis facilities, and
- hospices.

For each setting, we discuss Medicare's payment policies and summarize current issues of concern.

Payment for outpatient dialysis services

Individuals with ESRD—irreversible loss of kidney function—require either dialysis or kidney transplantation to survive. In 1972, the Social Security Act extended all Medicare Part A and Part B benefits to individuals with ESRD who are entitled to receive Social Security benefits. This entitlement is nearly universal, covering 93 percent of all people with ESRD in the United States. Total Medicare spending for these beneficiaries has outstripped expectations—reaching nearly $12 billion in 2000—primarily because of unanticipated growth in the ESRD population. The 331,000 enrolled ESRD beneficiaries in 1999 accounted for 0.8 percent of total Medicare enrollment, compared with only 0.1 percent of enrollment in 1974. This enrollment growth reflects population aging and improvements in clinical knowledge and technique that have enabled successful treatment of older patients and those with coexisting illnesses who might not have been treated 30 years ago.

Because of the scarcity of kidneys available for transplantation, most people with ESRD receive dialysis treatments three times per week in either freestanding or hospital-based facilities. Medicare spending for outpatient dialysis ($5.5 billion in 2000) accounts for 2 percent of total program expenditures but is a predominant share of revenues for dialysis facilities. Medicare pays dialysis facilities a predetermined payment for each dialysis treatment they furnish, using a mature payment system first implemented in 1983. The prospective payment—called the composite rate—is intended to cover the bundle of services, tests, drugs, and supplies routinely required for dialysis treatment and is only adjusted to account for differences in local input prices.

Even though technological advances have changed the provision of dialysis care since the composite rate was established, CMS has not modified the unit of payment. Although CMS has occasionally changed the dialysis bundle, it has not used explicit criteria to determine which services should be included. Consequently, the composite rate currently excludes several new injectable drugs and clinical laboratory tests that have diffused widely into medical practice over the past decade; providers are paid for these services based on their incurred costs. The BIPA requires the Secretary to:

- include in the composite rate by July 2002 diagnostic laboratory tests and drugs that are routinely used in furnishing dialysis care but are currently billed separately, and
- recommend to the Congress whether the composite rate should be updated annually or periodically.

Defining the dialysis products Medicare buys

Medicare covers two methods of dialysis—hemodialysis and peritoneal dialysis. In hemodialysis, a patient's blood is cycled through a dialysis machine, which filters out body waste. About 90 percent of all dialysis patients undergo hemodialysis three times per week in dialysis facilities.[40] Peritoneal dialysis uses the membrane lining the peritoneal cavity to filter excess waste products, which are then drained from the abdomen. Patients undergo peritoneal dialysis five to seven times per week in their homes.

The unit of payment is the dialysis treatment. The composite rate payment system differs from Medicare's other prospective payment systems because it uses only one product category to define the service bundle Medicare is buying. Although different equipment, supplies, and labor are needed for hemodialysis and peritoneal dialysis, the current system does not differentiate payment based on dialysis method.[41]

Setting product payment rates

The composite rate is intended to cover all operating and capital costs that efficient providers would incur in furnishing dialysis treatment episodes in dialysis facilities or in patients' homes. The base payment rate is $131 for hospital-based facilities and $127 for freestanding

40 Recently, clinicians have expressed growing interest in using daily hemodialysis furnished five to seven times per week in dialysis facilities or in patients' homes.

41 The Congress made an exception to this policy in 1989 for a new type of peritoneal dialysis. Medicare pays up to 130 percent of the composite rate for this dialysis method when patients deal directly with one dialysis supplier (not a dialysis facility).

facilities in 2002.[42] Medicare caps its payments to facilities at an amount equal to three dialysis sessions per week, although dialysis may be given more frequently.

The labor-related portion of the composite rate—40 percent in 2002—is adjusted for local market differences in input prices using a wage index created in 1987. This wage index blends 60 percent of a wage index based on 1980 Bureau of Labor Statistics hospital wage data with 40 percent of the fiscal year 1986 PPS hospital wage index. Both component wage indexes use labor markets based on 1980 definitions for MSAs and statewide rural areas. The blended wage index is limited by a floor and a ceiling; areas that have blended index values lower than 90 percent of the national average are raised to the 90 percent level (the wage index "floor"), while those with blended index values higher than 130 percent of the national average are lowered to the 130 percent level (the "ceiling"). Thus, the minimum payment is $121 and the maximum is $144 per dialysis treatment in 2002.

A dialysis facility may apply for an exception to its composite rate when dialysis costs exceed the base payment rate. The four circumstances that may justify a payment exception are: 1) serving an atypical patient mix, 2) furnishing services to patients who are using fewer than three dialysis sessions per week, 3) serving an isolated area in which the facility is essential to ensure beneficiaries' access to care, or 4) extraordinary circumstances, such as furnishing dialysis in an area affected by natural disaster.

Dialysis facilities are reimbursed for bad debt that results when, after a good faith effort, they are unable to collect some beneficiaries' 20 percent coinsurance amounts. Medicare also pays providers based on their incurred costs for certain laboratory tests and new injectable drugs that are widely used but not included in the dialysis service bundle.

Issues

The fundamental issue is whether the dialysis composite rate payment system needs to be overhauled. Action may be needed on every aspect of the payment system.

Defining a comprehensive payment bundle. Dialysis providers have strong financial incentives to control the costs of services included in the composite rate payment bundle, but weak incentives for controlling costs for those that are paid separately based on facilities' incurred costs. The composite rate bundle excludes new injectable drugs and laboratory tests that have diffused widely into medical practice. CMS is developing a system to incorporate these items in the payment bundle.

Rethinking the unit of payment. Some have questioned whether the composite rate's unit of payment (a single dialysis session) promotes efficient provision of high-quality care and whether it is consistent with providers' thinking about changes in treatment patterns that might improve quality.

Developing an effective dialysis product classification system. The design of the outpatient dialysis payment system may hamper beneficiaries' access to high-quality care because it does not account for differences in patient acuity and in dialysis dose and frequency that are known to affect providers' costs.

Ensuring adequate payment rates. Some have questioned whether the current base composite rate is set too low because it has been updated only four times since it was established in 1982. In contrast, the payment rates for certain new injectable drugs that are billed outside the bundle appear to be too high and their profitability is offsetting losses that some providers may experience in furnishing the services included in the bundle.

Updating payments. CMS has not routinely updated the composite rate, in part because it is not required to consider a periodic update. To address this issue, the BIPA requires the Secretary to develop by July 2002 update methods for the current payment system that account for projected inflation in input prices, anticipated scientific and technological advances, and changes in practice patterns and market conditions.

Payment for hospice services

Terminally ill beneficiaries (certified to have a projected life expectancy of six months or less) may elect to receive hospice care, which aims to help these patients continue as normal a life as possible and remain in their homes. Therefore, the hospice benefit covers a wide array of services, including:

- physician services;
- skilled nursing services;
- counseling (dietary, spiritual, bereavement, and other counseling services);
- medical social services;
- drugs and biologicals for pain control and symptom management;
- physical, occupational, and speech therapy;
- home health aide and homemaker services; and
- inpatient respite care.

To be eligible for hospice services, beneficiaries must give up other covered services related to curative treatment of the terminal condition, although Medicare still pays for unrelated care. Twenty percent of Medicare beneficiaries who died in 1998 used hospice care (Hogan 2001). Payments to hospices (almost $3 billion in 2000) represent a small part of total Medicare spending (about 1 percent), although Medicare makes up a large share of hospice revenues.

42 This $4 difference stems from the Omnibus Budget Reconciliation Act of 1981, in which the Congress mandated separate rates for these types of facilities to reflect differences in their overhead costs.

Medicare pays hospices for each day a beneficiary is eligible and under hospice care, regardless of the amount of services furnished on any given day. Per diem payment rates are based on a fee schedule with separate rates for four broad categories of care. The rate for each day is adjusted to reflect local market conditions.

Medicare's payment rates must be monitored to ensure that payment is adequate to maintain beneficiaries' access to high-quality hospice care.

Defining the hospice products Medicare buys and setting payment rates

For hospice services, Medicare sets predetermined daily payment rates according to a fee schedule for four broad categories of care: routine home care, continuous home care, inpatient respite care, or general inpatient care.[43] Patients are assigned to these categories based on the type of care they actually receive each day.

The daily payment rates represent payment in full for all costs that hospices incur in furnishing services identified in patients' care plans.[44] The initial payment level (base rate) per category is adjusted to account for differences in wage rates among markets. The labor-related portion of the base payment amount—69 percent for routine and continuous home care, 54 percent and 64 percent for inpatient respite care and general inpatient care, respectively—is adjusted by the hospice wage index for the location in which care is furnished and the result is added to the nonlabor portion. The base rates are updated annually by the projected increase in the acute care hospital MB index.

A hospice's annual aggregate payments are limited by a capped amount ($16,651 for fiscal year 2002) multiplied by the number of beneficiaries newly enrolled during the year. The capped amount is updated annually by the CPI-U.

Issues

The main issue for hospice services is whether payments are adequate to cover efficient providers' costs.

Ensuring adequate payments. The payment rates are based on old information from the Medicare hospice demonstration project in the early 1980s (GAO 2000, Huskamp et al. 2001). Although the initial rates have been updated for inflation over time, they may not be consistent with the costs hospices incur in furnishing care, potentially reducing beneficiaries' access to these services.

Other services

Medicare also pays for other services and products used by beneficiaries in the traditional fee-for-service program, including:

- ambulance services, and
- durable medical equipment.

For each of these payment systems, we describe Medicare's policies and current policy issues.

Payment for ambulance services

Medicare pays for both emergency and non-emergency ambulance services, including ground and air services, when the use of other means of transportation to health care services would be harmful to beneficiaries' health. Ambulance staff provide a range of services to stabilize and treat patients in transit.

Because Medicare has repeatedly delayed implementing an ambulance fee schedule, payments for these services are still based on providers' reported costs and charges. This approach provides few incentives for cost containment and often results in payment disparities among similar providers.

Ambulance providers are either hospital-based or freestanding, a distinction critical to current payment.[45] Hospital-based ambulance providers are paid based on their Medicare-allowed incurred costs. They are paid a base rate, which covers the costs of services and supplies, and a mileage payment. Freestanding providers are paid based on reasonable charges, subject to a cap, and can choose whether to be paid a bundled payment or bill separately for cost components. In billing Medicare, providers use procedure codes to distinguish different levels of services, including a range of Basic Life Support and Advanced Life Support services, various supplies, and mileage.

Concerns about inequities in payment, growth in expenditures, and inconsistent coverage policies among regions led the Congress to require CMS to develop a fee schedule. Several issues have delayed its adoption, including how to adjust for the higher costs incurred by low-volume providers, how to ensure that aggregate payments to ambulances are not reduced, and whether to require additional coding to document the medical necessity of services.

Defining the ambulance product Medicare buys

As of January 2000, nine HCPCS codes are used to distinguish the levels of services provided. Other codes are available to indicate the supplies used and mileage costs. Carriers may also require providers to report diagnosis codes to determine if the service was medically

43 Inpatient respite care provides short-term relief for a patient's caregiver; general inpatient care may be necessary to perform procedures for pain control or symptom management when they cannot be furnished in other settings.

44 Beneficiaries are responsible for a 5 percent copayment for drugs and biologicals, up to a maximum of $5 per prescription, and 5 percent of the reasonable cost of any respite care.

45 Technically, hospital-based ambulances are considered providers, while freestanding ambulances are considered suppliers. For the purposes of this chapter, we refer to both types as "providers".

necessary and therefore covered by Medicare. Payments are reduced when a beneficiary dies before the ambulance arrives at the scene.

Setting payment rates

Hospital-based ambulance providers receive a base rate and a payment for mileage for each trip. Payments are based on the provider's costs from the previous year, subject to an update factor established by Congress. The final payment is determined at the end of the hospital's fiscal year, as part of a year-end cost settlement process.

Freestanding ambulance providers choose whether to bill Medicare using an all-inclusive charge or separate charges for the different cost components (for example, mileage and supplies). Regardless of this choice, payment is set at the lowest of:

- the actual submitted charge,
- the provider's customary charge, which is its median charge for each procedure during the preceding year,
- the prevailing charge in the region, which is the 75th percentile of local providers' customary charges during the preceding year, or
- the inflation indexed charge (IIC), which is the lowest of the actual, customary, and prevailing charges in the preceding year, updated for inflation. The IIC was initiated in 1985.

Issues

The Congress mandated a fee schedule for ambulance services to make payments consistent with efficient providers' costs and give them incentives to furnish services efficiently. This schedule has not yet been implemented.

Implementing a fee schedule. CMS's proposed fee schedule, published in September 2000, would have established a classification system for ambulance services with relative values for each type of service. It proposed a base payment amount—called a conversion factor—based on providers' submitted claims, adjusted to account for varying costs of conducting business in different regions of the country. The base rate also would be adjusted upward for air services furnished in rural areas. A separately calculated payment would be made for mileage to account for costs attributable to the use of the ambulance vehicle. The proposed mileage rates varied for ground or air transport and included a 50 percent add-on to the mileage rate for the first 17 miles traveled with the patient on board in rural areas. Analysts have raised concerns about whether the proposed fee schedule adequately accounts for low-volume providers' costs, ensures that aggregate payments to ambulances are not reduced, and allows for a better coding method for documenting the medical necessity of services.

Payment for durable medical equipment

When medical equipment is needed at home to treat a beneficiary's illness or injury, it is covered under the durable medical equipment (DME) benefit. Medicare spent about $6 billion on DME in 2000, about 2 percent of program spending.

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

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

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

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

Medicare has paid DME suppliers using a fee schedule since 1986. Under the fee schedule, covered items are classified into product groups within six major classes. The payment amount for each product group is a weighted average of local and regional prices, updated annually by the CPI-U. Suppliers are generally paid either a monthly rate for rentals or a lump sum for purchased items. Medicare also covers the cost of repairs, maintenance, delivery, and supplies necessary to use purchased equipment. Beneficiaries are responsible for a 20 percent copayment.

The durable medical equipment Medicare buys

DME payments include a monthly rental fee or a lump-sum purchase fee. Under the DME fee schedule, Medicare sets prices for equipment by category and product group. Equipment is assigned to one of six categories based on its nature—whether or not it is inexpensive, needs frequent service, or is a rental item subject to an explicitly limited period of use. The six DME categories are:

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

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

The central issue in DME payment policy is the frequent failure of Medicare's payments to reflect current market prices. It is difficult for CMS to price DME in a way that is consistent with the market because the product definitions are too broad. Each product code has only one payment rate, but one product code can be used for many different items with varying prices in the retail market. Also, changing Medicare's payment rates in any way other than simple updating has been cumbersome.

The BBA gave Medicare the authority to apply a so-called test of inherent reasonability to some items that have well-developed retail markets; this allows CMS some price-setting flexibility. CMS is also conducting a competitive bidding project to test the effects of competition on prices for certain DME items.

Setting the product payment rates

To ensure beneficiaries' access to needed DME, the fee schedule must cover efficient suppliers' costs of furnishing equipment for rental or purchase. Generally, the current fees are an average of the allowed charges from 1986 and 1987, adjusted by the CPI-U to account for inflation.

Over time, the inflation-adjusted prices have failed to reflect changes in medical equipment technology and other factors that have caused market retail prices to diverge from Medicare's payment rates. Recent legislation established two alternatives to the inflation adjustment. One is that Medicare can adjust prices by as much as 15 percent in one year for DME that is frequently purchased by other payers. To make the price adjustment, CMS would use an inherent reasonableness test based on a survey of market prices. The other is that Medicare can freeze some prices or put a limit on the amount of the annual increase.

Medicare uses different methods among the six broad equipment categories for capturing variations in prices due to local market conditions. In some instances, Medicare sets a separate fee schedule for each state based on local allowed charges in 1986–87. In other cases, Medicare uses 10 regional fee schedules in which the prices in each region are based on an average of allowed charges in the constituent states. Both the state and regional schedules are subject to floors and ceilings to limit the variability in prices across the country. A third method is an item-by-item determination by the carrier. Rental payments are subject to a national payment limit. The applicable fee schedule is determined by the location of beneficiaries' residences rather than the location of the DME provider. All program payments are reduced by the 20 percent coinsurance paid by beneficiaries.

Issues

The primary issue in DME is the adequacy of payment and Medicare's ability to keep payments in line with market prices.

Ensuring appropriate payments. CMS continues to seek ways of keeping its fee schedule in line with prevailing market prices. The BBA streamlined the inherent reasonability test to allow CMS some price-setting flexibility. CMS is also conducting a competitive bidding project to test the effects of creating a market for certain DME items.

Medicare+Choice plans

Medicare beneficiaries may choose to receive their Medicare benefits from a private plan participating in the Medicare+Choice (M+C) program rather than from the traditional program. Under some M+C plans, beneficiaries may receive additional benefits beyond those offered under traditional Medicare and may pay additional premiums. Medicare pays plans a capitated rate for the 14 percent of beneficiaries currently enrolled. These payments amounted to $40 billion in 2000, 16 percent of total Medicare spending.

Medicare payment rates for M+C plans are based on enrolled beneficiaries' characteristics and the counties in which they live. Medicare uses beneficiaries' characteristics—primarily age and sex—to develop a measure of their expected relative risk for covered health spending. The payment rate for a plan enrolling a beneficiary is then calculated using the base rate for the beneficiary's county of residence, adjusted for the beneficiary's expected relative health risk. The base rate for each county is based on its historic average per capita spending in the traditional Medicare program, local levels of input prices, and the health risk characteristics of its Medicare population.

Controversy has surrounded the payment rate formulas. In response to concerns that plans could not survive in areas with low payment rates (because of historically low per capita Medicare spending), the Congress set floors to raise the lowest rates. Controversy has also surrounded the adjustment for health risk. Many analysts have been concerned that the current risk adjusters, based mostly on demographic variables, do not account for predictable differences in spending for covered services among beneficiaries. Although more accurate risk adjusters have been proposed, M+C plans have argued that they require burdensome data collection.

Defining the Medicare+Choice products Medicare buys

Under the M+C program, Medicare buys calendar months of insurance coverage for its beneficiaries from private plans. The coverage must include all Medicare benefits, except that plans may limit enrollees' choices of providers more narrowly than under the traditional fee-for-service program.

Medicare's payment rates for a month of coverage are based on beneficiaries' counties of residence and on their relative expected cost, as predicted by demographic and diagnostic health factors. The county-level rates are determined administratively, based on statutory formulas. The 2002 rate for a county is the highest of three values:

- a floor rate of $553 for counties in metropolitan areas with 250,000 or more people, or $500 for all other counties;

- the county's 2001 rate increased by 2 percent; or
- a 50/50 blend of an input price-adjusted national average rate and an updated historical rate based on the county's 1997 payment rate. (All blended rates are adjusted by a budget neutrality factor that constrains national payments. For 2002, budget neutrality could not be achieved; thus, the blended rates were not applicable.)

Medicare currently calculates a beneficiary's relative expected cost—as compared with the average expected cost for all Medicare beneficiaries—based on seven factors:

- age,
- sex,
- whether the beneficiary has ESRD,
- whether the beneficiary is also covered by Medicaid,
- whether the beneficiary is institutionalized,
- whether the beneficiary is currently covered as an active worker under an employer-sponsored plan, and
- a health risk factor currently based on diagnoses made during any Medicare-covered hospital stays by the beneficiary during the preceding year.

Setting product payment rates

The original theory behind setting payment rates for private plans was that the rates should be based on how much it would cost the traditional Medicare program to provide coverage for those that enrolled in the plans. Before the BBA, rates were set at 95 percent of the expected cost of providing coverage under the traditional Medicare program. Medicare would thus save 5 percent of the expected spending on behalf of a beneficiary when the beneficiary enrolled in a private plan.

The theory raised several concerns in practice, however. Beneficiaries' spending in the traditional Medicare program varies substantially across counties; per capita spending in the highest county was three-and-a-half times that for the lowest county. Therefore, the payment rates for private plans were three-and-a-half times higher in some counties than in others. As a result of low payment rates and other factors, few beneficiaries in lower-spending areas had private plans available to them, while most beneficiaries in higher-spending counties had plans with extra benefits available. The BBA changed the rate-setting to the approach described earlier in an effort to reduce rate variation across the country and entice private plans into serving more counties.

The three county rates are updated annually. The floor rates are updated by the national average growth in per-capita spending in the traditional Medicare program. The county's prior year rates are increased by 2 percent, thus serving as a minimum update of 2 percent. Finally, the blended rates are recalculated and adjusted by a percentage constrained by budget neutrality. In most years, the blended rates were not applicable because of the budget-neutrality constraint.

Issues

Two issues have dominated recent discussion of M+C payment rates: variation in the county-level rates and risk adjustment of those rates.

Ensuring appropriate payments. The Congress has been concerned because many M+C plans have withdrawn from the program since passage of the BBA. Some members want to see further compression of the county-level rates to attract plans to low-rate areas. Other members want rates once again to reflect the costs of the traditional Medicare program in local areas. They believe that putting plans on more even footing with the traditional program would enable plans to thrive in areas with high spending. This debate is ongoing (see Chapter 4).

Improving methods for risk-adjusting payments. Medicare's method of risk-adjusting payments has also been controversial. Many critics have claimed that the current risk-adjustment factors do a poor job of predicting cost. Consequently, plans have strong financial incentives to select relatively healthy beneficiaries because their per capita payment rates will not be reduced to reflect healthier enrollees. The BIPA requires CMS to revise the risk-adjustment method to include factors related to diagnoses from outpatient settings. The health plan industry has complained that data collection efforts required to support a risk-adjustment system based on outpatient diagnostic encounter data are too burdensome. CMS responded to complaints by suspending encounter data collection that would have been used to develop the specific system. Currently, the type of system to be used is under development and CMS has not yet determined system specifics.

Further information on how Medicare pays for services

Several sources are available to those seeking further information on how Medicare pays for services it furnishes to beneficiaries. For example, each year, Commerce Clearing House publishes a series that explains Medicare payment policy, complete with references to the law and regulations (CCH 2001). Readers interested in updating the information contained in this chapter also can refer to CMS's final rules for each payment system, generally published annually in the Federal Register.

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