
# Medicare Payment Policies

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# Summary

Medicare is a federal insurance program that pays for covered health services for most persons 65 years of age and older and for most permanently disabled individuals under the age of 65. Part A of the program, the Hospital Insurance program, covers hospital, post-hospital, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of complementary medical services including physician, laboratory, outpatient hospital services, and durable medical equipment. Part C provides private plan options for beneficiaries enrolled in both Parts A and B. Part D is an optional outpatient prescription drug program.

Medicare has established specific rules for payment of covered benefits. Some, such as physician services and most durable medical equipment, are based on fee schedules. Some payments are based, in part, on a provider's bid (an estimate of the cost of providing a service) relative to a benchmark (the maximum amount Medicare will pay). Bids and benchmarks are used to determine payments in Medicare Parts C and D. Payments for some items of durable medical equipment in specified locations are to be based on competitive bidding, starting in 2011. Many services, however, including inpatient and outpatient hospital care, are paid under different prospective payment systems (PPSs). In general, the program provides for annual updates to these payment amounts. The program also has rules regarding the amount of cost sharing, if any, which beneficiaries can be billed in excess of Medicare's recognized payment levels. Unlike other services, Medicare's outpatient prescription drug benefit can be obtained only through private plans. Further, while all Part D plans must meet certain minimum requirements, they differ in terms of benefit design, formulary drugs, and cost-sharing amounts.

Medicare payment policies and potential changes to these policies are of continuing interest to Congress. The Medicare program has been a major focus of deficit reduction legislation since 1980. With certain exceptions, reductions in program spending have been achieved largely through regulating payments to providers, primarily hospitals and physicians. The Balanced Budget Act of 1997 (P.L. 105-33, BBA) modified some existing payment policies, including changing underlying payment methodologies and updates to payment amounts. Subsequent legislation increased Medicare funding to mitigate the financial impact of some BBA provisions. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA), too, modified payment methods and established payment increases for some providers. Most recently, the Tax Relief and Health Care Act of 2006 (P.L. 109-432, TRHCA); the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173, MMSEA); the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275, MIPPA); the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5); and the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, PPACA), as modified by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), have affected Medicare's payments.

This report provides an overview of Medicare payment rules by type of service, outlines current payment policies, and summarizes the basic rules for program updates. This report will be updated at least annually.

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# Introduction

Medicare is a federal insurance program that pays for covered health services for most persons 65 years of age and older and for most permanently disabled individuals under the age of 65. Part A of the program, the Hospital Insurance program, covers hospital services, up to 100 days of post-hospital skilled nursing facility services, post-institutional home health visits, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of medical services including physician services,[1] laboratory services, durable medical equipment, and outpatient hospital services. Part B also covers some home health visits. Part C (also known as Medicare Advantage, or MA) provides private plan options, such as managed care, for beneficiaries who are enrolled in both Parts A and B. Part D provides optional outpatient prescription drug coverage.

# Medicare Payment Principles

In general, the total payment received by a provider for covered services provided to a Medicare beneficiary is composed of two parts: a program payment from Medicare plus any beneficiary cost-sharing that is required.[2] (The required beneficiary out-of-pocket payment may be paid by other insurance, if any.)[3] Medicare has established specific rules governing its program payments for all covered services as well as for beneficiary cost sharing as described below.

## Medicare Payment Rules

Medicare has established specific rules governing payment for covered services. For example, the program pays for most acute inpatient and outpatient hospital services, skilled nursing facility services, and home health care under a prospective payment system (PPS) established for the particular service; under PPS, a predetermined rate is paid for each unit of service such as a hospital discharge or payment classification group. Payments for physician services, clinical laboratory services, and certain durable medical equipment covered under Part B are made on the basis of fee schedules.[4] Certain other services are paid on the basis of reasonable costs or reasonable charges. In general, the program provides for annual updates of the program payments to reflect inflation and other factors. In some cases, these updates are linked to the consumer price

[1] Certain non-physicians providers (such as physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, psychologists, and social workers) are permitted to furnish services and bill Medicare under the physician fees schedule. In this report, the term "physician" or "practitioner" will include all such providers unless otherwise specified.

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

[3] For more information, see CRS Report RL31223, *Medicare: Supplementary "Medigap" Coverage*.

[4] The MMA required the Secretary to establish and implement a competitive bidding program for durable medical equipment, prosthetics, orthotics and certain supplies. The program would pay for certain items based on the bids of qualified suppliers in designated areas. The first round of the competitive bidding program started July 1, 2008. However, MIPPA stopped the program, terminated all contracts with suppliers, and required the Secretary to rebid the first round in 2009. Expansion of the program was delayed by two years until 2011. See CRS Report R41211, *Medicare Durable Medical Equipment: The Competitive Bidding Program*.

index for all urban consumers (CPI-U) or to a provider-specific market basket (MB) index which measures the change in the price of goods and services purchased by the provider to produce a unit of output. However, updates to the physician fee schedule are determined by a statutory formula, known as the sustainable growth rate (SGR) system, which links annual updates to how cumulative actual expenditures compare with a cumulative expenditures target.[5]

## Beneficiary Out-of-Pocket Payments

There are two aspects of beneficiary payments to providers: required cost-sharing amounts (either coinsurance, copayments, or deductibles) and the amounts that beneficiaries may be billed over and above Medicare's recognized payment amounts for certain services. For Part A, coinsurance and deductible amounts are established annually; these payments include deductibles and coinsurance for hospital services, coinsurance for skilled nursing facilities (SNFs), no cost sharing for home health services, and nominal cost sharing for hospice care.[6] For Part B, beneficiaries are generally responsible for premiums, which range from $110.50 to $353.60 in 2010, depending on the beneficiary's income, a $155 deductible in 2010 (updated annually by the increase in the Part B premium), and a coinsurance payment of 20% of the established Medicare payment amounts.[7] For Part C, cost sharing is determined by the private plans. Through 2005, the total of premiums[8] for *basic* Medicare benefits and cost sharing (deductibles, coinsurance, and co-payments) charged to a Part C enrollee could not exceed actuarially determined levels of cost sharing for those same benefits under original Medicare. This meant that plans could not charge a premium for Medicare-covered benefits without reducing cost-sharing amounts. Beginning in 2006, the constraint on a plan's ability to charge a premium for *basic* Medicare benefits was lifted. The bidding mechanism established by the MMA allows plans to charge a premium to cover *basic* Medicare benefits if the costs to the plan exceed the maximum amount CMS will pay for Medicare-covered benefits. The MMA eliminated the explicit inverse relationship between cost sharing for *basic* Medicare benefits and a premium for *basic* Medicare benefits. Aggregate enrollee cost sharing under Part C is now only constrained by the actuarial value of cost sharing under original Medicare.[9] However, also beginning in 2006, the Secretary has expanded authority to negotiate or reject a bid from a managed care organization in order to ensure that the bid

[5] For details, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*.

[6] In 2010, for each spell of illness, a beneficiary deductible is $1,100 to cover day 1 through 60 in a hospital. The daily coinsurance charge is $275 for each day from 61 through 90. After 90 days in the hospital, a beneficiary may draw down 60 lifetime reserve days with a daily coinsurance of $550.

[7] Generally, Part B premiums are set to cover 25% of the actuarial cost of Part B services for an aged beneficiary. Income-related Part B premiums were introduced by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA) and first took effect in 2007. For more information, see CRS Report R40082, *Medicare: Part B Premiums* and CRS Report R40561, *The Effect of No Social Security COLA on Medicare Part B Premiums*.

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

[9] Plans must also adhere to specific constraints on enrollee cost-sharing. Beginning in 2011, cost sharing under an MA plan may not exceed that under original Medicare for certain services, such as chemotherapy treatment, renal dialysis, skilled nursing care and other services identified by the Secretary.

reasonably reflects the plan's revenue requirements. Part D cost sharing includes a deductible, co-payments, and catastrophic limits on out-of-pocket spending.

For most services, there are rules on amounts beneficiaries may be billed over and above Medicare's recognized payment amounts. Under Part A, providers agree to accept Medicare's payment as payment in full and cannot bill beneficiaries amounts in excess of the coinsurance and deductibles. Under Part B, providers and practitioners are subject to limits on the amounts they can bill beneficiaries for covered services depending on their participation status in the Medicare program. A *participating physician* agrees to accept the approved fee schedule amount as payment in full (assignment) for all services delivered to Medicare beneficiaries, of which 80% is paid by the Medicare program and the beneficiary is responsible for the 20% coinsurance plus any unmet deductible. Physicians who do not agree to accept assignment on all Medicare claims in a given year are referred to as *nonparticipating physicians***.** Nonparticipating physicians may or may not accept assignment for a given service. If they do not, they may charge beneficiaries more than the fee schedule amount on nonassigned claims; for physicians, these *balance billing* charges are subject to certain limits.

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

# Recent Congressional Actions with Respect to Program Payments

Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been a major focus of deficit reduction legislation, as outlined below. With a few exceptions, savings in program spending have been achieved largely through reductions in the updates to provider payments, primarily hospitals, physicians, and MA plans. However, even when payments are frozen (as has been the case with payments to acute care hospitals, inpatient rehabilitation facilities, long term care hospitals, and with the physician fee schedule), Medicare spending continues to increase each year.

Most recently the Patient Protection and Affordable Care Act (P.L. 111-148, PPACA), as amended, is estimated to achieve substantial program savings through permanent reductions in the maximum amount paid to MA plans, and reductions in the annual updates to Medicare's fee-for-service (FFS) providers (other than physicians' services). The anticipated savings from FFS providers is substantially due to the application of a productivity adjustment. (Productivity, in general, is a measure of output produced relative to the amount of work required to produce it.[10]) PPACAs update reductions mark a departure from most previous legislative actions to reduce Medicare program spending, first, because it is a permanent adjustment to (non-physician)

[10] For a general discussion on productivity measurement and growth, see CRS Report RL34677, *Productivity Growth: Trends and Prospects*. For a detailed description of the productivity adjustment as it applies to Medicare FFS providers, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

payment updates,[11] and second, because, in general, it specifies that the adjustment allows for negative payment updates and as such, payment rates for a year may be less than for a preceding year. Once the estimates of savings are known, Congress may wish to revisit this issue whether rates are much higher or much lower than originally estimated. As in the case of physician payment updates, it is unclear whether Congress will allow providers to be paid less under this new provision. As the Medicare Trustees emphasized in the 2010 Annual Report, "the very favorable financial outcomes that would be experienced if the productivity adjustments can be sustained in the long range" are highly dependent on the actual implementation of the provisions, although the trustees "recognize the great uncertainty associated with achieving this outcome."[12]

# Recent Legislative History

The Balanced Budget Act of 1997 (P.L. 105-33, BBA 97) achieved significant savings to the Medicare program by slowing the rate of growth in payments to providers and by enacting structural changes to the program.[13] A number of health care provider groups stated that actual Medicare benefit payment reductions resulting from BBA were larger than were intended, leading to facility closings and other limits on beneficiary access to care. In November 1999, Congress passed a package of funding increases to mitigate the impact of some BBA 97 provisions on providers. This measure, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), is part of a larger measure known as the Consolidated Appropriations Act for 2000 (P.L. 106-113).[14] Further adjustments were made by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), part of the larger Consolidated Appropriations Act, 2001 (P.L. 106-554).[15] In addition to increasing Medicare payment rates, the subsequent legislation mandated the development or refinement of PPSs for different Medicare covered services. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA)[16] contained a major benefit expansion in adding prescription drug coverage; Congress included a number of provisions that affected payments to providers and changed administrative and contracting procedures. Further modifications were made to Medicare payments in the Deficit Reduction Act of 2005 (P.L. 109-171, DRA)[17]; the Tax Relief and Health Care Act of 2006 (P.L. 109-432, TRHCA); the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173, MMSEA)[18]; and the Medicare Improvements for Patients and Providers Act

[11] The Balanced Budget Act of 1997 first introduced the concept of productivity adjusted payment increases for physician services, however, Congress has overwritten the effects of the productivity adjustment in recent years. For more information, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*.

[12] The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2010 Annual Report," August 5, 2010, http://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf.

[13] For more information, see CRS Report 97-802, *Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)*.

[14] For more information, see CRS Report RL30347, *Medicare: Changes to Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) Provisions*.

[15] For more information, see CRS Report RL30707, *Medicare Provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554)*.

[16] For more information, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*.

[17] For more information, see CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*.

[18] For more information, see CRS Report RL34360, *P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP* (continued...)

of 2008 (P.L. 110-275, MIPPA)[19]; the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5);[20] and the Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) as modified by the Health Care and Education Reconciliation Act (P.L. 111-152, HCERA).[21]

This report provides a guide to Medicare payment rules by type of benefit. It includes a summary of current payment policies and basic rules for updating payment amounts. It is updated to reflect the most recent legislative changes to the program and payment updates available through September 2010. This report will be updated when additional information is available.

(...continued)

*Extension Act of 2007*.

[19] For more information, see CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*.

[20] For more information, see CRS Report R40181, *Selected Health Funding in the American Recovery and Reinvestment Act of 2009*.

[21] For more information, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

# Medicare Payment Policies

# Part A

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

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Operating PPS for inpatient services provided by acute hospitals (Operating IPPS) | Medicare pays acute care hospitals using a prospectively determined payment for each discharge. A hospital's payment for its operating costs is calculated using a national standardized amount adjusted by a wage index associated with the area where the hospital is located or where it has been reclassified. Payment also depends on the relative resource use associated with the diagnosis related group (DRG) to which the patient is assigned. A new Medicare Severity DRG (MS-DRG) patient classification system is being phased in starting in FY2008. Medicare pays additional amounts for cases with extraordinary costs (outliers); indirect medical education (IME) (see below); and for hospitals serving a disproportionate share (DSH) of low-income patients (see below). IME and DSH payments are made through adjustments within IPPS so that hospitals receive more money for each Medicare discharge. Additional payments may be made for cases that involve qualified new technologies that have been approved for special add-on payments. Hospitals in Hawaii and Alaska receive a cost-of-living adjustment (COLA). Certain services are reimbursed outside of IPPS. | After accounting for certain budget neutrality adjustments, IPPS payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket (MB) index. This is a fixed price index that measures the change in the price of goods and services purchased by hospitals to create one unit of output. The update for operating IPPS is established by statute. Under DRA, hospitals that do not submit required quality data in FY2007 and each subsequent year will have the applicable MB percentage reduced by two percentage points. Any MB reduction does not apply when computing the applicable percentage increase in subsequent years. The update penalty for not reporting quality data will end in FY2012. In its FY2008 rule, CMS established prospective budget neutrality adjustments of -1.2% in FY2008, -1.8% in FY2009 and -1.8% in FY2010 because of anticipated increases in measured severity of illness attributable to coding changes or documentation improvements (coding creep) associated with the new MS-DRGs. P.L. 110-90 reduced the adjustment to 0.6% in FY2008 and 0.9% in FY2009, but permits offsets to IPPS rate increases in FY2010, FY2011, and FY2012 to account for coding creep increases in FY2008 and FY2009 above these amounts. The law did not address the scheduled adjustment of an additional 1.8% decrease in FY2010 However, | **For FY2010**, effective for discharges after April 1, 2010, hospitals that submitted the required quality data received an update of 1.85%. The national standardized amount for these hospitals was $5,212.02. Hospitals that did not submit the quality data received a reduced update of -0.15%. The national standardized amount for these hospitals was $5,111.64.<br><br>**For FY2011**, hospitals that submitted the required quality data receive the full MB increase of 2.6% (which was subject to a 2.9% reduction to account for coding improvements). The national standardized amount for these hospitals is $5,164.11 Hospitals that did not submit the quality data receive a reduced update of 0.6% (which was also subject to a 2.9% reduction to account for coding improvements.)The national standardized amount for these hospitals is $5,063.21<br><br>Both standardized amounts are lower in FY2011 than in FY2010. |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| | | in FY2010, CMS did not adjust the update for coding improvements. In FY2011, CMS estimates that an additional 5.8% adjustment is warranted for the coding improvements that increased payments in FY2008 and FY2009 (to recoup payments retroactively). Also, an additional 3.9% adjustment is necessary to eliminate the full effect of coding improvements on future payments. CMS reduced the FY2011 update by 2.9%, half the amount of the retroactive recoupment adjustment. The HITECH Act established update penalties for hospitals that are not meaningful electronic health record (EHR) users starting in FY2015. Specifically, these hospitals will have an update reduction of 25% in FY2015, 50% in FY2016, and 75% in FY2017 and in subsequent years. PPACA established a schedule of annual reductions in the update for FY2009 through FY2019. The reduction in the FY2010 IPPS update of 0.25 percentage points became effective for discharges starting April 1, 2010. The annual update will include a productivity adjustment starting October 1, 2011. The PPACA update reductions may result in a negative update for that year. | |
| Capital IPPS for short-term general hospitals (Capital IPPS) | Medicare's capital IPPS is structured similarly to its operating IPPS for short-term general hospitals. A hospital's capital payment is based on a prospectively determined federal payment rate, depends on the DRG to which the patient is assigned, and is adjusted by a hospital's geographic adjustment factor (which is calculated from the hospital's wage index data). Capital IPPS includes an IME and DSH adjustment (see below). Starting in FY2008, the IME adjustment will be phased out over a 3-year period. Additional payments are made for outliers (cases with significantly higher costs above a certain threshold). Certain hospitals may also qualify for additional payments under an exceptions process. A new hospital is paid | Updates to the capital IPPS are not established in statute. Capital rates are updated annually by the Centers for Medicare and Medicaid (CMS) according to a framework which considers changes in the prices associated with capital-related costs as measured by the capital input price index (CIPI) and other policy factors, including changes in case mix intensity, errors in previous CIPI forecasts, DRG recalibration, and DRG reclassification. Other adjustments include those that implement budget neutrality with respect to recalibration of DRGs, documentation and coding changes resulting from the switch to MS-DRGs that do not reflect real changes in patient severity of illness, real outlier payments, changes in the geographic | The capital IPPS update for **FY2010** was 1.2% After adjustments, the FY2010 capital federal rate was $429.56 for discharges starting April 1, 2010.<br><br>The capital IPPS update for **FY2011** is 1.5%, which reflects an estimated increase in the CIPI of 1.2% and a forecast error correction of 0.3%. After applying other adjustments including a coding improvement reduction, the FY2011 federal capital rate is $420.01, which is lower than the FY2010 rate. |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| | 85% of its allowable Medicare inpatient hospital capital-related costs for its first two years of operation. | adjustment factor, and exception payments. In FY2011, the capital update increase was reduced by 2.9% to account for coding improvements. | |
| Disproportionate share hospital (DSH) adjustment | Approximately 2,800 hospitals receive the additional payments for each Medicare discharge based on a formula which incorporates the number of patient days provided to low-income Medicare beneficiaries (those who receive Supplemental Security Income (SSI)) and Medicaid recipients. A few urban hospitals, known as "Pickle Hospitals," receive DSH payments under an alternative formula that considers the proportion of a hospital's patient care revenues that are received from state and local indigent care funds. The percentage add-on for which a hospital will qualify varies according to the hospital's bed size or urban or rural location. The DSH adjustment for most categories of hospitals is capped at 12%. Urban hospitals with more than 100 beds, rural hospitals with more than 500 beds, Medicare dependent hospitals (MDHs, see below), and rural referral centers (RRC, see below) are exempt from the 12% DSH adjustment cap. | No specific update. The amount of DSH spending in any year is open-ended and varies by the number of Medicare discharges as well as the type of patient seen in any given hospital. | CBO estimates DSH spending (in both operating and capital IPPS) at $10.4 billion in **FY2009** and $10.8 billion in **FY2010** (August 2010 baseline). |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Indirect Medical Education (IME) adjustment | The indirect medical education (IME) adjustment is one of two types of payments to teaching hospitals for graduate medical education (GME) costs (see also direct GME below). Medicare increases both its operating and capital IPPS payments to teaching hospitals; different measures of teaching intensity are used in the operating and capital IPPS. For both IPPS payments, however, the number of medical residents who can be counted for the IME adjustment is capped, based on the number of medical residents as of December 31, 1996. As established by BBA 97, teaching hospitals also receive IME payments for their Medicare Part C discharges. (See also Medicare Part C below.) | The IME adjustment is not subject to an annual update. BBA 97 reduced the IME adjustment in operating IPPS from a 7.7% increase for each 10% increase in a hospital's ratio of interns to beds (IRB), a measure of teaching intensity in operating IPPS; by FY2001, the IME adjustment was to be 5.5%. However, the scheduled decreases were delayed by subsequent legislation. As established by MMA, the IME adjustment was set at 5.5% in FY2008 and subsequently. | No specific update. The amount spent on IME depends in part on the number of Medicare discharges in teaching hospitals in any given year. CBO estimates the IME payments (for both capital and operating IPPS) to be about $6.2 billion in **FY2009** and $6.3 billion in **FY2010** (August 2010 baseline). |
| Direct graduate medical education (direct GME) payments | Direct GME costs are excluded from IPPS and paid outside of the DRG payment on the basis of updated hospital-specific costs per resident amount (PRA), the number of weighted full-time equivalent (FTE) residents, and Medicare's share of total patient days in the hospital (including those days attributed to Medicare manged care enrollees). There is a hospital-specific cap on the number of residents in the hospital for direct GME payments. Also, the hospital's FTE count is based on a three-year rolling average; a specific resident may count as half of a FTE, depending on the number of years spent as a resident and the length of the initial training associated with the specialty. Certain combined primary care residency programs receive special recognition in this count. In certain circumstances, irect GME payments can be made to nonhospital providers. | In general, direct GME payments are updated by the increase in the consumer price index for all urban consumers (CPI-U). As established by BBRA and subsequently amended, however, the update amount that any hospital receives depends upon the relationship of its PRA to the national average PRA. Hospitals with PRAs below the floor (85% of the locality-adjusted, updated, and weighted national PRA) are raised to the floor amount. Teaching hospitals with PRAs above the ceiling amount (140% of the national average, adjusted for geographic location) will receive a lower update than other hospitals (CPI-U minus two percentage points) for FY2003-FY2013. Hospitals that have PRAs between the floor and ceiling receive the CPI-U as an update amount. | Hospitals below 140% of the national average from FY2004-FY2013 receive an update of CPI-U. Hospitals above 140% of the national average for that time period will receive no update. CBO estimates direct GME payments of $3.1 billion in **FY2009** and 3.2 billion in **FY2010** (August 2010 baseline). |

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

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Sole Community Hospitals (SCHs)— | An SCH receives the higher of the following payment rates as the basis of reimbursement: | Target amounts for SCHs are updated by an "applicable percentage increase" which is | **For FY2010**, starting for discharges on April 1, 2010, hospitals that submitted the required |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| facilities located in geographically isolated areas and deemed to be the sole provider of inpatient acute care hospital services in a geographic area based on distance, travel time, severe weather conditions, and/or market share as established by specific criteria set forth in regulation (42 CFR 412.92). | the current IPPS base payment rate, or its hospital-specific per-discharge costs from either FY1982, 1987, or 1996, updated to the current year. Under MIPPA, for cost reporting periods beginning on or after January 1, 2009, an SCH will be able to elect payment based on its FY2006 hospital-specific payment amount per discharge. This amount will be increased by the annual update starting for discharges on or after January 1, 2009. An SCH may receive additional payments if the hospital experiences a decrease of more than 5% in its total inpatient cases due to circumstances beyond its control. An SCH receives special consideration for reclassification into a different area. Starting for services on January 1, 2006, CMS increased outpatient prospective payment system (OPPS) payments to rural SCHs by an additional 7.1%. | specified by statute and is often comparable to the IPPS update. (See description for IPPS hospitals). | quality data received an update of 1.85%. Hospitals that did not submit the quality data received a reduced update of -0.15%.<br><br>**For FY2011,** hospitals that submitted the required quality data receive the full MB increase of 2.6% (which was subject to a 2.9% reduction to account for coding improvements.) Hospitals that did not submit the quality data receive a reduced update of 0.6% (which was also subject to a 2.9% reduction to account for coding improvements.) |
| Medicare dependent hospitals (MDHs)—small rural hospitals with a high proportion of patients who are Medicare beneficiaries (have at least 60% of acute inpatient days or discharges attributable to Medicare in FY1987 or in two of the three most recently audited cost reporting periods). As specified in regulation (42 CFR 412.108), they cannot be an SCH and must have 100 or fewer beds. | BBA 97 reinstated and extended the MDH classification, starting on October 1, 1997, and extending to October 1, 2001. The sunset date for the MDH classification was subsequently extended to September 30, 2011 by DRA. Until October 1, 2006, an MDH was paid the federal rate plus 50% of the amount that the rate is exceeded by the hospital's target amount based on either its updated FY1982 or FY1987 cost per discharge. DRA provided that an MDH would be able to elect payments based on using a percentage of its FY2002 hospital-specific cost starting October 1, 2006. An MDH's payments would be based on 75% of the adjusted hospital-specific cost starting for discharges on October 1, 2006. DRA also excluded MDHs from the 12% DSH adjustment cap for discharges starting October 1, 2006. An MDH may receive additional payments if its inpatient cases decline more than 5% due to circumstances beyond its control. | Target amounts for MDHs are updated by an "applicable percentage increase" which is specified by statute and is often comparable to the IPPS update. | For FY1996 and thereafter, the update for MDHs is the same as for all IPPS hospitals. These updates are also used to increase the hospital-specific rate applicable to an MDH.<br><br>**For FY2010**, starting for discharges on April 1, 2010, hospitals that submitted the required quality data received an update of 1.85%. Hospitals that did not submit the quality data received a reduced update of -0.15%.<br><br>**For FY2011,** hospitals that submitted the required quality data receive the full MB increase of 2.6% (which was subject to a 2.9% reduction to account for coding improvements.) Hospitals that did not submit the quality data receive a reduced update of 0.6% (which was also subject to a 2.9% reduction to account for coding improvements). |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Rural Referral Centers (RRCs)—relatively large hospitals, generally in rural areas, that provide a broad array of services and treat patients from a wide geographic area as established by specific criteria set forth in regulation. (42 CFR 412.96). | RRCs payments are based on the IPPS for short-term general hospitals. RRCs are exempt from the 12% DSH adjustment cap. Also, RRCs receive preferential consideration for reclassification to a different area. | RRCs receive the operating and capital IPPS updates specified for short-term general hospitals. | See updates specified for operating and capital IPPS for short-term general hospitals. |

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

| Provider/service | General payment policy | General update policy | Recent update |
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| Inpatient Rehabilitation Facilities (IRFs)—freestanding hospitals and hospital-based distinct part units that treat a percentage of patients with a defined set of conditions and meet certain established conditions of participation. As established by MMSEA, starting July 1, 2007, the IRF compliance threshold (which determines whether a facility is an IRF or an acute care hospital) is set at 60%; comorbidities are included as | As of January 1, 2002, Medicare's payments to a rehabilitation facility are based on a fully implemented IRF-PPS and 100% of the federal rate which is a fixed amount per discharge. This PPS encompasses both capital and operating payments to IRFs, but does not cover the costs of approved educational programs, bad debt expenses, or blood clotting factors, which are paid for separately. The IRF-PPS payment for any Medicare discharge will vary depending on the patient's impairment level, functional status, comorbidity conditions, and age. These factors determine which of the 87 Case Mix Groups (CMGs) is assigned to the inpatient stay. Within each of these CMGs, patients are further assigned to one of four tiers based on any comorbidities they may have. Five other CMGs are used for patients discharged before the fourth day (short stay outliers) and for those who die in the facility. Generally, IRF payments are reduced or increased for certain case level adjustments, such as early transfers, short-stay outliers, patients who die before transfer, and high cost outliers. Payments also depend upon | Starting in FY2006, the IRF-PPS update is based on the MB reflecting 2002 cost structures from rehabilitation, psychiatric, and long-term care hospitals (RPL-MB). The RLP-MB includes an update estimate for capital as well as operating costs. MMSEA establishes the IRF update factor at 0% in FY2008 and FY2009, starting for discharges on April 1, 2008. PPACA established a schedule of annual reductions in the update for FY2009 through FY2019. The reduction in the FY2010 update of 0.25 percentage points became effective for discharges starting April 1, 2010. The FY2011 update reduction is 0.25 percentage points. The annual update will include a productivity adjustment starting October 1, 2011. The PPACA update reductions may result in a negative update for that year. | The **FY2010** IRF-PPS update was 2.5% before the enactment of PPACA which imposed a 0.25 percentage point reduction on the FY2010 update (to 2.25%) for discharges starting April 1, 2010. Starting then, the base federal rate for IRFs was $13,627.<br><br>The **FY2011** IRF-PPS update is 2.5% before the PPACA reduction of 0.25 percentage point, and other budget neutrality adjustments. The final FY2011 federal rate for IRFs is $13,860. |

| Provider/service | General payment policy | General update policy | Recent update |
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| qualifying conditions. To be paid as an IRF, an entity must have 60% of its inpatients with one of 13 conditions including stroke, spinal cord injury, brain injury, neurological disorder, burns, and certain arthritis related conditions. | facility-specific adjustments to accommodate for variations in area wages, percentage of low income patients (LIP) served by the hospital (a DSH adjustment), and rural location (rural IRFs receive increased payments, about 19% more than urban IRFs.) Starting in FY2006, an IME adjustment is included; IRFs in Alaska and Hawaii do not receive a COLA adjustment. The IRF-PPS is not required to be budget neutral; total payments can exceed the amount that would have been paid if this PPS had not been implemented. | | |
| Long-Term Care Hospitals and satellites or onsite providers (LTCHs)—acute general hospitals that are excluded from IPPS with a Medicare inpatient average length of stay (ALOS) greater than 25 days. | Effective October 1, 2002, LTCHs are paid on a discharge basis under a DRG-based PPS, subject to a five-year transition period. The LTCH-PPS encompasses payments for both operating and capital-related costs of inpatient care but does not cover the costs of approved educational programs, bad debt expenses, or blood clotting factors which are paid for separately. The LTCH-PPS payment for any Medicare discharge will vary depending on the patient's assignment into a Medicare severity- LTC-DRG. LT-DRGs are based on reweighted IPPS MS-DRGs. Payments for specific patients may be increased or reduced because of case-level adjustments, such as short stay cases, interrupted stay cases, readmitted cases from co-located providers and high costs outliers. Payments also depend upon facility-specific adjustments such as variations in area wages and include a COLA for hospitals in Alaska and Hawaii. No adjustments are made for the percentage of low income patients served by the hospital (DSH), rural location, or IME. The LTCH-PPS is required to be budget neutral; total payments must equal the amount that would have been paid if PPS had not been implemented. | The LTCH update is not specified in statue. CMS has established a policy to update the LTCH rates based on the most recent estimate of the rehabilitation, psychiatric, and long-term care (RPL) market basket adjusted to account for improved coding practices. CMS changed the effective date of the annual update from October 1 to July 1 of each year, starting July 2003. MMSEA established a three-year moratorium period during which the Secretary will not be able to apply certain payment policies, including payments for short stay outliers or the one-time adjustment to LTCH prospective payments to ensure budget neutrality. In the RY2009 final rule, CMS changed the effective date of the annual update back to October 1, beginning October 1, 2009. In order to implement the change, RY2009 will be a 15-month rate year, from July 1, 2008, through September 30, 2009. PPACA established a schedule of annual reductions in the update for RY2009 through RY2019. The reduction in the RY2010 update of 0.25 percentage points became effective for discharges starting April 1, 2010. The RY2011 update reduction is 0.5 percentage points. The update will include a productivity adjustment starting October 1, 2011. The PPACA update reductions may result in a negative update for | In **RY2010** (starting October 1, 2009) the LTCH federal payment rate was increased by 2.0% which reflects a 2.5% MB increase adjusted for case-mix changes attributed to documentation and coding improvements. For discharges starting April 1, 2010, the update will be reduced by 0.25 percentage points; the LTCH federal payment rate is set at $39,794.95 for discharges starting on that date until September 30, 2010.<br><br>In **RY2011** (starting October 1, 2010) the LTCH federal payment rate was increased by a 2.5% MB update subject to 2.5% reduction for coding improvements that happened in FY2008 and FY2009, and the PPACA reduction of 0.5 percentage points. The update factor for LTCH federal rate was -0.49%. The LTCH federal payment rate is set at $39,599.95 for discharges starting on October 1, 2010. |

| Provider/service | General payment policy | General update policy | Recent update |
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| | | that year. | |
| Psychiatric hospitals and distinct part units—include those primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of people with mental illness. | Starting January 1, 2005, Medicare pays for services provided in inpatient psychiatric facilities (IPF) using a per-diem based PPS. Established with a three-year transition period, the IPF-PPS incorporates patient-level adjustments for specified DRGs, selected comorbidies, and in certain cases, age of the patient. Facility-level adjustments for relative wages, teaching status and rural location are also included. IPFs in Hawaii and Alaska will receive a COLA adjustment. Medicare per diem payments are higher in the earlier days of the psychiatric stay. Also, the per diem payment for the first day of each stay is 12% higher in IPFs with qualifying (full-service) emergency departments than in other IPFs. An outlier policy for high-cost cases is included. Patients who are discharged from an IPF and return within three days are considered readmissions of the same case. IPFs also receive an additional payment for each eletroconvulsive therapy treatment furnished to a patient. Finally, under the stop-loss provision, during the three-year transition period ending in 2008, an IPF is guaranteed at least 70% of the aggregate payments that would have been made under the prior payment system. | The IPF update is not specified in statue. CMS has established a policy to update the per diem rates based on the most recent estimate of the rehabilitation, psychiatric, and long-term care market basket (RPL-MB) The IPF-PPS payments must be projected to equal the amount of total payments that would have been made under the prior payment system. The initial calculation of the per diem payment included a 17.46% reduction to account for standardization to projected TEFRA (the prior payment system) payments, a 2% reduction to account for outlier payments, a 0.39% reduction to account for the stop-loss provision and a 2.66% reduction to account for a behavioral offset (to reflect changing utilization under the new payment system). PPACA established a schedule of annual reductions in the update starting RY2011 through RY2020. The reduction in the RY2011 IPF update of 0.25 percentage points effective July 1, 2010. The update will include a productivity adjustment starting July 1, 2012. The PPACA update reductions may result in a negative update for that year. | The RPL-MB update for **RY2010** was 2.1% After applying a wage index budget neutrality factor of 1.0009, the federal base payment is $651.76 per day. The RPL-MB update for **RY2011** is 2.4%,reduced by the PPACA offset of 0.25 percentage points and a wage index budget neutrality offset of 0.9999. The federal base payment is $665.71 per day. |
| Children's and cancer hospitals:<br><br>***Children's hospitals*** are those engaged in furnishing services to inpatients who are predominantly individuals under the age of 18. ***Cancer hospitals*** are generally recognized by the National | Children's and cancer hospitals are paid on a reasonable cost basis, subject to TEFRA payment limitations and incentives. Each provider's reimbursement is subject to a ceiling or target amount that serves as an upper limit on operating costs. Depending upon the relationship of the hospital's actual costs to its target amount, these hospitals may receive relief or bonus payments as well as additional bonus payments for continuous improvement (i.e., facilities whose costs have been consistently less than their limits may receive additional money). Newly established hospitals | An update factor for reimbursement of operating costs is established by statute. Starting in FY2006, the IPPS operating MB increase is used to update the target amounts. The amount of increase received by any specific hospital will depend upon the relationship of the hospital's costs to its target amount. There is no specific update for capital costs. | The update for **FY2010** was 2.1%.<br><br>The update for **FY2011** is 2.6%. |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Cancer Institute as either a comprehensive or clinical cancer research center; are primarily organized for the treatment of and research on cancer (not as a subunit of another entity); and have at least 50% of their discharges with a diagnosis of neoplastic disease. See 42 CFR 412.23(f). | receive special treatment. Providers that can demonstrate that there has been a significant change in services and/or patients may receive exceptions payments. The capital costs for these hospitals are reimbursed on a reasonable cost basis. | | |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Critical Access Hospitals (CAHs) are limited-service facilities that are located more than 35 miles from another hospital (15 miles in certain circumstances) or designated by the state as a necessary provider of health care; offer 24-hour emergency care; have no more than 25 acute care inpatient beds and have a 96-hour average length of stay. Beds in distinct-part skilled nursing facility, psychiatric or rehabilitation units operated by a CAH do not count toward the bed limit. | Medicare pays CAHs on the basis of the reasonable costs of the facility for inpatient and outpatient services. CAHs may elect either a cost-based hospital outpatient service payment or an all-inclusive rate which is equal to a reasonable cost payment for facility services plus 115% of the fee schedule payment for professional services. Ambulance services that are owned and operated by CAHs are reimbursed on a reasonable cost basis if these ambulance services are 35 miles from another ambulance system. MMA provided that inpatient, outpatient, and swing bed services provided by CAHs will be paid at 101% of reasonable costs for cost reporting periods beginning January 1, 2004. Starting July 1, 2009, clinical diagnostic laboratory services furnished by a CAH will be paid as outpatient hospital services at 101% of costs without regard to whether the individual is physically present in the CAH, or in a SNF or a clinic (including a rural health clinic) that is operated by a CAH at the time the specimen is collected. | No specific update policy. | No specific update policy. |

## Table 4. Skilled Nursing Facility (SNF) Care

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Skilled Nursing Facility (SNF) care | SNFs are paid through a prospective payment system (PPS) which is composed of a daily ("per-diem") urban or rural base payment amount adjusted for case mix and area wages.<br><br>The **federal per diem** payment is intended to cover all the services provided to the beneficiary that day, including room and board, nursing, therapy, and prescription drugs. Some costs are excluded from PPS and paid separately such as physician visits, dialysis and certain high cost prosthetics and orthotics.<br><br>The case-mix adjustment to the base per diem rate adjusts payments for the treatment and care needs of Medicare beneficiaries and categorizes individuals into groups called resource utilization groups (RUGs). **The RUGs system** uses patient assessments to assign a beneficiary to one of 53 categories and to determine the payment for the beneficiary's care. Patient assessments are done at various times during a patient's stay and their RUG may change. The federal payment is also adjusted to account for variations in area wages, using the hospital wage index.<br><br>According to the FY2010 CMS Final SNF rule, the **SNF RUG**-III methodology was to be replaced with a revised RUG-IV methodology. And, the Minimum Data Set (MDS) 2.0 patient assessment tool, used to calculate RUG categories, among other things, is replaced with the MDS 3.0 system on October 1, 2010. For FY2010, PPACA delays the implementation of this revised RUG methodology until FY2011. According to the SNF PPS Notice for FY2011, CMS will apply interim payment rates that reflect the use of MDS 3.0 and a hybrid RUG-III | The urban and rural federal **per diem** payment rates are increased annually by an update factor determined, in part, by the projected increase in the SNF market basket (MB) index. This index measures changes in the costs of goods and services purchased by SNFs. Each year, the update may include an adjustment to account for the MB forecast error for previous years. Since FY2008, when the difference between the estimated MB update and the actual increase is greater than 0.5 percentage points, payments to SNFs are updated to account for this forecast error. When the difference is less than 0.5 percentage points, no adjustments are made.<br><br>For FY2011, SNFs will receive the full MB update.<br><br>Starting in FY2012, all SNF MB updates will be subject to the productivity adjustment. | For **FY2010**, SNFs receive the full MB increase of 2.2%.<br><br>For **FY 2011**, SNFs will receive a MB increase of 2.3%, adjusted by a negative 0.6 percentage point forecast error from FY2009, for a total net increase of 1.7%. |

| Provider/service | General payment policy | General update policy | Recent update |
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| | system which incorporates certain RUG-IV' revisions in concurrent therapy and a change to the look-back period.<br><br>Starting on October 1, 2004, MMA increased payments for **AIDS patients** in SNFs by 128%. Unlike other PPSs, the SNF PPS statute does not provide for an adjustment for extraordinarily costly cases (an "outlier" adjustment). DRA reduced payments to SNFs for beneficiary bad debts to 70% for non-duals (individuals who are not enrolled in both Medicare and Medicaid). Bad debt payments for dual eligibles (individuals enrolled in both Medicare and Medicaid) remain at 100%. | | |

## Table 5. Hospice Care

| Provider/Service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Hospice care | Payments for hospice care contain three separate components that are adjusted annually. These components are the payment rates, the hospice wage index, and the cap amount. Limited cost sharing applies to outpatient drugs and respite care.<br><br>**Payment rates** are based on one of four prospectively determined rates which correspond to four different levels of care (i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care) for each day a beneficiary is under the care of the hospice.<br><br>The **hospice wage index** is used to adjust payment rates to reflect local differences in area wage levels. This index is established using the most current hospital wage data available.<br><br>Total payments to a hospice are subject to an aggregate **cap** that is determined by multiplying the cap amount for a given year by the number of Medicare beneficiaries who receive hospice services during the year. Medicare payments to hospices that exceed this amount must be returned to the Medicare program.<br><br>Not earlier than October 1, 2013, **PPACA** requires the Secretary to implement budget neutral revisions to the methodology for determining hospice payments for routine care and other services. | Each of the three components are updated annually. The prospective **payment rates** are updated by the increase in the hospice market basket (MB). Since FY2003 updates have been at the full hospital MB percentage increase.<br><br>For FY2010 – FY2012, hospice providers receive the full MB update. For FY2013, the **MB update** will be reduced by 0.3% and adjusted by the productivity factor. For FY2014 – FY2019, a 0.3% reduction to the MB will be contingent upon the level of the insured population relative to the projection of the insured population for 2009. Only if the level of non-elderly insured population is 5 or fewer percentage points above the projections will the MB be reduced by 0.3%.<br><br>The **hospice wage index** is updated to reflect updates in the hospital wage index and any changes to the definition of Metropolitan Statistical Areas (MSAs). In 1997, a hospcie wage index **budget neutrality adjustment factor (BNAF)** was instituted to account for differences in hospice payments as a result of a change in the data source used to adjust for geographic differences in labor from the 1983 Bureau of Labor Statistics data to the hospital wage index. The final rule for FY2010 phases-out the BNAF over 7 years. As a result, the BNAF was reduced by 10 percent in FY2010, and will be reduced by an additional15 percent each year from FY2011 through FY2016.<br><br>The hospice **cap** amount is increased or decreased annually by the same percentage as the medical care expenditure category of the CPI-U. | The **FY2010 payment rates** were updated by the MB of 2.1%. This update was affected by the BNAF reduction of 10% in the FY2010 Hospice Wage Index. The net effect was a 1.4% increase in payment rates. The national hospice base payment rates for care furnished during **FY2010** were as follows: routine home care—$142.91; continuous home care—$834.10 for 24 hours or $34.75 per hour; inpatient respite care—$147.83 per day; and general inpatient care—$406.94 per day.<br><br>The **FY2011 payment rates** are as follows: routine home care—$146.82; continuous home care—$856.12 for 24 hours or $35.67 per hour; inpatient respite care—$159.65 per day; and general inpatient care—$652.27 per day.<br><br>The latest hospice **cap** amount for the cap year November 1, 2009, through October 31, 2010, is an aggregated $23,874.98 per beneficiary. For the year ending on October 31, 2009, it was an aggregated $23,014.50 per beneficiary. |

# Part B

**Table 6. Physicians**

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Physicians | Payments for physicians services are made on the basis of a fee schedule. The fee schedule assigns relative values to services. These relative values reflect physician work (based on time, skill, and intensity involved), practice expenses (including the cost of nurses and other staff), and malpractice expenses. The relative values are adjusted for geographic variations in the costs of practicing medicine. These geographically adjusted relative values are converted into a dollar payment amount by a conversion factor. Assistants-at-surgery services (provided by physicians) are paid 16% of the fee schedule amount.<br><br>Anesthesia services are paid under a separate fee schedule (based on base and time units) with a separate conversion factor.<br><br>Medicare payments for most professional services equal 80% of the fee schedule amount; patients are liable for the remaining 20%. | The conversion factor is updated each year by a formula specified in law. The update percentage equals the Medicare Economic Index (MEI, which measures inflation) subject to an adjustment to match spending under the cumulative sustainable growth rate (SGR) system. (The SGR is linked, in part, to changes in the gross domestic product per capita.) The adjustment sets the conversion factor so that projected spending for the year will equal allowed spending by the end of the year. Application of the SGR system led to a 5.4% reduction in the conversion factor in 2002. Additional reductions were slated to take effect in subsequent years. However, P.L. 108-7 allowed for revisions in previous estimates used for the SGR calculation, thereby permitting an update of 1.6% effective March 1, 2003. MMA provided that the update to the conversion factor for 2004 and 2005 could not be less than 1.5%. DRA froze the 2006 rate at the 2005 level, TRHCA froze the 2007 rate at the 2006 level; and MMSEA provided that the level for the first six months of 2008 is increased by 0.5%. MIPPA extended this 0.5% increase through the end of 2008 and provided for a 1.1% increase in 2009. Under current law, the conversion factor update can not be more than three percentage points above nor more than seven percentage points below the MEI, however, several of the bills that have averted the SGR reductions have included language that has overridden this condition. | Congress has passed several bills that have overridden the reduction in the update factor that would have been required for 2010 under the SGR formula. For January 1 through May 31, the update to the conversion factor was set to 0% as a result of three separate acts. For the six months from June 1 through November 30, 2010, the update to the conversion factor is 2.2%. Unless Congress passes additional legislation, a substantial reduction in the update factor will be required on December 1, 2010.<br><br>PPACA included several modifications to Medicare physician reimbursement, including bonus payments for primary care services and for successfully reporting quality measures as well as many adjustments to the methodologies for calculating payments. (See CRS report on Medicare and PPACA for details).<br><br>For many years, prior to the passage of MIPPA, beneficiary payments for outpatient mental health services equaled 50% of the fee schedule amounts. MIPPA included a mental health parity provision to be phased in over 5 years. For services provided before Jan. 1, 2010, beneficiaries pay 50% of the covered charges (after meeting their deductible); beginning Jan. 1, 2014, outpatient mental health services will be covered at the same rate (80%) as other Part B services. |

## Table 7. Nonphysician Practitioners

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| (a) Physician Assistants | Separate payments are made for physician assistant (PA) services, when provided under the supervision of a physician, but only if no facility or other provider charge is paid. Payment is made to the employer (such as a physician). The PA may be in an independent contractor relationship with the employer.<br><br>The recognized payment amount equals 85% of the physician fee schedule amount (or, for assistant-at-surgery services, 85% of the amount that would be paid to a physician serving as an assistant-at-surgery). Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory for PA services. | See physician fee schedule. | See physician fee schedule.<br><br>In a skilled nursing facility (SNF), Medicare law allows physicians, as well as nurse practitioners and clinical nurse specialists who do not have a direct or indirect employment relationship with a SNF, but who are working in collaboration with a physician, to certify the need for post-hospital extended care services for purposes of Medicare payment. PPACA includes a provision that allows a physician assistant who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes, beginning on or after January 1, 2011. |
| (b) Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) | Separate payments are made for NP or CNS services, provided in collaboration with a physician, but only if no other facility or other provider charge is paid.<br><br>The recognized payment amount equals 85% of the physician fee schedule amount (or, for assistant-at-surgery services, 85% of the amount that would be paid to a physician serving as an assistant-at-surgery). Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory. | See physician fee schedule. | See physician fee schedule. |
| (c) Nurse midwives | The recognized payment amount for certified nurse midwife services equals 65% of the physician fee schedule amount. Nurse midwives can be paid directly. Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory. | See physician fee schedule. | See physician fee schedule. |
| (d) Certified Registered Nurse Anesthetists (CRNAs) | CRNAs are paid under the same fee schedule used for anesthesiologists. Payments furnished by an anesthesia care team composed of an anesthesiologist and a CRNA are capped at | See physician fee schedule. | See physician fee schedule. |

| Provider/service | General payment policy | General update policy | Recent update |
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| | 100% of the amount that would be paid if the anesthesiologist was practicing alone. The payments are evenly split between each practitioner. CRNAs can be paid directly. Assignment is mandatory for services provided by CRNAs. Regular Part B cost sharing applies. | | |
| (e) Clinical Psychologists and Clinical Social Workers | The recognized payment amount for services provided by a clinical social worker is equal to 75% of the physician fee schedule amount.<br><br>Services in connection with the treatment of mental, psychoneurotic, and personality disorders of a patient who is not a hospital inpatient are subject to the mental health services limitation. In these cases Medicare pays 50% of incurred expenses and the patient is liable for the remaining 50%. Otherwise, regular Part B cost sharing applies. Assignment is mandatory for services provided by clinical psychologists and clinical social workers. | See physician fee schedule. | See physician fee schedule. |
| (f) Outpatient physical or occupational therapy services | Payments are made under the physician fee schedule.<br><br>Medicare coverage for outpatient therapy services, including physical therapy, speech-language pathology services, and occupational therapy have limits or "caps." To accommodate patients with therapy needs that exceed the cap, Congress created an exceptions process that allows for specific diagnoses and procedures to receive Medicare coverage even after a beneficiary has met the therapy cap for the year.<br><br>In 1999, an annual $1,500 per beneficiary limit applied to all outpatient physical therapy services (including speech-language pathology services), except for those furnished by a hospital outpatient department. A separate $1,500 limit applied to all outpatient occupational therapy services except for those furnished by hospital outpatient departments. | Updates in fee schedule payments are dependent on the update applicable under the physician fee schedule. The $1,500 limits were to be increased by the increase in the MEI beginning in 2002; however, application of the limits was suspended until September 1, 2003. At that time the limits were $1,590. MMA suspended the application of the limits beginning December 8, 2003-December 31, 2005. The limits were restored January 1, 2006. DRA required the Secretary to establish an exceptions process for 2006 for certain medically necessary services. TRHCA extended the exceptions process through 2007; MMSEA extended the process an additional six months. MIPPA extended the exceptions process through December 31, 2009. The 2006 limits were $1,740; the 2007 limits were $1,780, the 2008 limits were $1,810, and the 2009 limits were $1,840. | See physician fee schedule.<br><br>The **CY2009** limits or "caps" were $1,840. The **CY2010** limits are $1,860.<br><br>However, the Temporary Extension Act of 2010, H.R. 4691 extended the exceptions process through March 31, 2010 and PPACA extended the exceptions process for therapy caps through December 31, 2010. |

| Provider/service | General payment policy | General update policy | Recent update |
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| | Therapy services furnished as incident to physicians professional services were included in these limits.<br><br>The $1,500 limits were to apply each year. However, no limits applied from 2000-2005, except for a brief period in 2003. The limits were restored in 2006; however, an exceptions process has applied in each year since the limits were reintroduced in 2006 .<br><br>Regular Part B cost sharing applies. Assignment is optional for services provided by therapists in independent practice; balance billing limits apply for non-assigned claims. Assignment is mandatory for other therapy services. | | |

## Table 8. Clinical Diagnostic Laboratory Services

| Provider/service | General payment policy | General update policy | Recent update |
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| Clinical diagnostic laboratory services | Clinical lab services are paid on the basis of area-wide fee schedules. The fee schedule amounts are periodically updated. There is a ceiling on payment amounts equal to 74% of the median of all fee schedules for the test. Assignment is mandatory. No cost sharing is imposed. | Generally, the Secretary of HHS is required to adjust the payment amounts annually by the percentage change in the CPI, together with such other adjustments as the Secretary deems appropriate. Updates were eliminated for 1998 through 2002. MMA eliminated updates for 2004-2008.<br><br>The annual clinical laboratory test fee schedule update adjustment for 2009-2013 will be the percentage increase or decrease in the CPI for all urban consumers minus 0.5 percentage points. MIPPA repealed the Medicare Competitive Bidding Demonstration Project for Clinical Laboratory Services.<br><br>MIPAA clarified the payment for clinical laboratory services in CAHs. Beginning July 1, 2009, clinical diagnostic laboratory services furnished by a CAH will be reimbursed as outpatient hospital services at 101% of costs without regard to whether the individual who receives the service is physically present in the CAH, or in a skilled nursing home or a clinic (including a rural health clinic) that is operated by a CAH at the time the specimen is collected. | The fee schedules were updated by 1.1% in **2003**. Per MMA, no update was made for **2004, 2005, 2006, 2007, or 2008**. In **2009**, the update was 4.5%. For **2010**, the update is -1.9%.<br><br>PPACA modified provider updates based on the MB or CPI minus full productivity estimates for all Parts A and B providers and suppliers who are subject to a MB or CPI update. (See above for details.) For the clinical laboratory test fee schedule, the modification will replace the scheduled 0.5% payment reduction for CY2011 through CY2013 with a full productivity adjustment for CY2011 and subsequent years. A 1.75 percentage point reduction to the update in CY2011 through CY2015 will be established; this reduction may result in a negative update. The productivity adjustment factor will be applied to the CPI-U starting in CY2011, but in the application of the adjustment will not be able to reduce the increase to less than zero.<br><br>PPACA authorized a two-year demonstration project, beginning on July 1, 2011, that will make separate payments to laboratories for complex diagnostic laboratory tests provided to Medicare beneficiaries and provided a one year extension (ending July 1, 2011) for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds to be paid on the basis of reasonable cost. |

## Table 9. Preventive Services

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Pap smears; pelvic exams | Medicare covers screening pap smears and screening pelvic exams once every two years; annual coverage is authorized for women at high risk. Payment is based on the clinical diagnostic laboratory fee schedule. Assignment is mandatory. No cost sharing is imposed. | See clinical laboratory fee schedule. A national minimum payment amount applies for pap smears. | See clinical laboratory fee schedule. Minimum payment for pap smears in **2010** is $15.13 (down 1.9%, or $0.29, from 2009). |
| Screening mammograms | Coverage is authorized for an annual screening mammogram. Payment is made under the physician fee schedule. The deductible is waived; regular Part B coinsurance applies. Assignment is optional. Balance billing limits apply on non-assigned claims. | See physician fee schedule. | See physician fee schedule. |
| Colorectal screening | Coverage is provided for the following procedures for the early detection of colon cancer: (1) screening fecal occult blood tests (for persons over 50, no more than annually); (2) screening flexible sigmoidoscopy (for persons over 50, no more than once every four years and 10 years after a screening colonoscopy for those not at high risk for colon cancer); (3) screening flexible colonoscopy for high-risk individuals (limited to one every two years) and for those not at high risk, every 10 years or four years after a screening sigmoidoscopy; and (4) barium enemas (as an alternative to either a screening flexible sigmoidoscopy or screening colonoscopy in accordance with the same screening parameters established for those tests).<br><br>Payments are based on rates paid for the same procedure when done for a diagnostic purpose. Fecal occult blood tests are paid under the laboratory fee schedule; other tests are paid under physician fee schedule. If a sigmoidoscopy or colonoscopy results in a biopsy or removal of a lesion, it would be classified and paid as the procedure with such biopsy or removal, rather | See physician fee schedule and laboratory fee schedule. | See physician fee schedule and laboratory fee schedule. |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| | than as a diagnostic test. Assignment is mandatory for fecal occult blood tests and no cost sharing applies. Assignment is optional for sigmoidoscopies and colonoscopies. DRA specified that the Part B deductible does not apply for screenings, effective January 1, 2007. Balance billing limits apply on non-assigned claims. | | |
| Prostate cancer screening | Medicare covers an annual prostate cancer screening test. Payment is made under the physician fee schedule. | See physician fee schedule. | See physician fee schedule. |
| Glaucoma screening | Medicare covers an annual glaucoma screening for persons with diabetes, persons with a family history of glaucoma, African-Americans age 50 and over, and Hispanic Americans age 65 and over. Payment is made under the physician fee schedule. | See physician fee schedule. | See physician fee schedule. |
| Diabetes outpatient self-management training | Medicare covers services furnished by a certified provider. Payment is made under the physician fee schedule. | See physician fee schedule. | See physician fee schedule. |
| Medical nutrition therapy services | Coverage is authorized for certain individuals with diabetes or renal disease. Payment equals 85% of the amount established under the physician fee schedule for the service if it had been furnished by a physician. | See physician fee schedule. | See physician fee schedule. |
| Bone mass measurements | Bone mass measurements are covered for certain high-risk individuals. Payments are made under the physician fee schedule. In general, services are covered if they are provided no more frequently than once every two years. | See physician fee schedule. | See physician fee schedule. |
| Ultrasound screenings for abdominal aortic aneurysms | Ultrasound screenings for abdominal aortic aneurysms are covered for individuals who: (1) receive a referral for such screening during the initial preventive services exam; (2) have not had such a screening paid for by Medicare; and (3) have a family history of abdominal aortic aneurysm or manifest certain risk factors. | See physician fee schedule. | See physician fee schedule. |

## Table 10. Telehealth

| Provider/Service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Telehealth services | Medicare pays for services furnished via a telecommunications system by a physician or practitioner, notwithstanding the fact that the individual providing the service is not at the same location as the beneficiary. Payment is equal to the amount that would be paid under the physician fee schedule if the service had been furnished without a telecommunications system. A facility fee is paid to the originating site (the site where the beneficiary is when the service is provided). | Current law established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31, 2002 at $20. The facility fee for telehealth services provided on or after January 1 of each subsequent calendar year is the amount for the previous year increased as of the first day of the subsequent year by the percentage increase in the Medicare Economic Index (MEI).<br><br>MIPPA added certain entities as originating sites eligible for for payment of telehealth services. Eligible distant site physicians and practitioners who provide services to beneficiaries located at the expanded list of sites may now be paid for qualifying telehealth services. This expanded list includes hospital-based or critical access hospital-based renal dialysis centers (including satellites); skilled nursing facilities (SNFs); and/or community mental health centers (CMHCs.) | |

## Table 11. Durable Medical Equipment (DME)

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Durable Medical Equipment (DME) | Except in designated DMEPOS Competitive Bidding Areas, DME is paid on the basis of a fee schedule. Items are classified into five groups for determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than $150 or which are purchased at least 75% of the times); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, fee schedule rates are established locally and are subject to national limits. The national limits have floors and ceilings. The floor is equal to 85% of the weighted average of all local payment amounts and the ceiling is equal to 100% of the weighted average of all local payment amounts. Assignment is optional. Balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies. MMA required the Secretary to begin a program of competitive acquisition for DME, prosthetics and orthotics in which payments for these items would be based on the bids of winning suppliers. Competitive acquisition was to begin in 10 metropolitan statistical areas (MSAs) in 2007, expanding to 80 MSAs in 2008, and additional areas in 2009. The first round of bids were submitted on September 25, 2007, and the program began on July 1, 2008. However, MIPPA stopped the program, terminated all contracts with suppliers and required the Secretary to rebid the first round in 2009. Expansion of the program was delayed by two years until 2011. PPACA expanded the number of areas in round two to 91 and requires the Secretary to expand the program or apply competitive rates to remaining areas by 2016. | In general, fee schedule amounts are updated annually by the CPI-U.<br><br>Updates were eliminated for 1998-2000; payments were increased by the CPI-U for 2001; and payments were frozen for 2002. MMA eliminated the updates for 2004-2008.<br><br>To pay for the delay in the competitive acquisition program, MIPPA reduced the fee schedule update for 2009 by 9.5% for all items, services and accessories included in round 1 of the competitive bidding program. For 2010 the fee schedule update will be the increase in the CPI-U.. Starting in 2011 PPACA requires the fee schedule update for DME to be subject to a productivity adjustment, which may result in a negative update. | The update for **CY2003** was 1.1%. As required by MMA, there were no updates for **CY2004, CY2005, CY2006, CY2007, and CY2008**.<br><br>In **CY2009**, the following 10 items were subject to a 9.5% reduction: oxygen supplies and equipment; standard power wheelchairs, scooters and related accessories; complex rehabilitative power wheelchairs and related accessories; mail-order diabetic supplies; enteral nutrients, equipment, and supplies; continuous positive airway pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies; hospital beds and related accessories; negative pressure wound therapy pumps and related supplies and accessories; walkers and related accessories; and support surfaces, including group 2 mattresses and overlays.<br><br>In **CY2009**, all items not subject to the 9.5% reduction received a 5.0% update.<br><br>For the **CY2010** update, the CPI-U for the applicable period is -1.4%, however Medicare set the update at 0.0%. |

## Table 12. Prosthetics and Orthotics

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Prosthetics and orthotics | Except in designated DMEPOS competitive bidding areas as described above, prosthetics and orthotics are paid on the basis of a fee schedule. These rates are established regionally and are subject to national limits which have floors and ceilings. The floor is equal to 90% of the weighted average of all regional payment amounts and the ceiling is equal to 120% of the weighted average of all regional payment amounts. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies. | Fee schedule amounts are updated annually by the CPI-U. MMA eliminated the updates for 2004-2006.<br>Starting in 2011 PPACA requires the fee schedule update for prosthetics and orthotics to be subject to a productivity adjustment, which may result in negative update. | The update for **CY2003** was 1.1%. As required by MMA, there were no updates for **CY2004, CY2005** and **CY2006.** The update for **CY2007** was 4.3%. The update for **CY2008** was 2.7%. The update for **CY2009** was 5.0%. For the **CY2010** update, the CPI-U for the applicable period is -1.4%, however Medicare set the update at 0.0%. |

## Table 13. Surgical Dressings

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Surgical Dressings | Surgical dressings are paid on the basis of a fee schedule. Payment levels are computed using the same methodology as the durable medical equipment fee schedule (see above). Assignment is optional; balance billing limits do not apply to non-assigned claims. Regular Part B cost sharing applies. | See durable medical equipment fee schedule.<br>Starting in 2011 PPACA requires the fee schedule update for medical supplies to be subject to a productivity adjustment, which may result in negative update. | The update for **CY2003** was 1.1%. There was no update for **CY2004**, **CY2005, CY2006, CY2007**, and **CY2008**. The update for **CY2009** was 5.0%. For the **CY2010** update, the CPI-U for the applicable period is -1.4%, however Medicare set the update at 0.0%. |

## Table 14. Parenteral and Enteral Nutrition (PEN)

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Parenteral and Enteral Nutrition (PEN) | Except in designated DMEPOS competitive bidding areas as described above, parenteral and enteral nutrients, equipment, and supplies are paid on the basis of the PEN fee schedule. Prior to 2002, PEN was paid on a reasonable charge basis (see below under Miscellaneous Items and Services). The fee schedule amounts are based on payment amounts made on a national basis to PEN suppliers under the reasonable charge system. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies. | Fee schedule amounts are updated annually by the CPI-U.<br><br>MIPPA reduced the fee schedule update for 2009 by 9.5% for all items, services and accessories included in round 1 of the competitive bidding program. Enteral nutrition was included in the first round of competitive bidding, and is thus subject to the 9.5% fee schedule reduction in CY2009. Parenteral nutrition was not included in round 1.<br><br>Starting in 2011 PPACA requires the fee schedule update for parenteral and enteral nutrition to be subject to a productivity adjustment, which may result in a negative update. | In **CY2009** Enteral nutrients, equipment and supplies were subject to the 9.5% reduction while parenteral nutrients received a 5.0% update.<br><br>For the **CY2010** update, the CPI-U for the applicable period is -1.4%, however Medicare set the update at 0.0%. |

## Table 15. Miscellaneous Items and Services

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Miscellaneous services | Miscellaneous items and services here refers to those services still paid on a reasonable charge basis. Included are such items as splints, casts, home dialysis supplies and equipment, therapeutic shoes, certain intraocular lenses, and transfusion medicine. These charges may not exceed any of the following fee screens: (1) the supplier's customary charge for the item, (2) the prevailing charge for the item in the locality, (3) the charges made to the carrier's policyholders or subscribers for comparable items, (4) the inflation-indexed charge. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies. | Payments for reasonable charge items are calculated annually. Carriers determine a supplier's customary charge level. Prevailing charges may not be higher than 75% of the customary charges made for similar items and services in the locality during the 12-month period of July 1- June 30 of the previous calendar year. The inflation-indexed charge is updated by the CPI-U. | The update to the inflation-indexed charge for **CY2007** was 4.3%. The update to the inflation-indexed charge for **CY2008** was 2.7%. The **CY2009** update was 5.0%. For the **CY2010** update, the CPI-U for the applicable period is -1.4%, however Medicare set the update at 0.0%. |

## Table 16. Ambulatory Surgical Centers (ASCs)

| Provider/service | General Payment policy | General update policy | Recent update |
|---|---|---|---|
| Ambulatory Surgical Centers (ASCs) | Starting January 1, 2008, Medicare will pay for surgery-related facility services provided in an ASC using a payment system based on the hospital outpatient prospective payment system (OPPS). The new payment system will be implemented over a four-year transition period. The ASC payment system uses the same payment groups (APCs) as the OPPS. Many of the ASC relative weights procedures will be the same as in OPPS. Certain services will be eligible for separate payments. The relative weights will be multiplied by a conversion factor (average payment amount) to get a payment for a specific procedure. The ASC conversion factor is based on a percentage of the OPPS conversion factor set to ensure budget neutrality between the old ASC payment system and the new one. CMS uses different methods to set payments for new office-based procedures, separately payable radiology services, separately payable drugs and device intensive services. | MMA eliminated the payment update for FY2005 under the prior payment system, changed the update cycle to a calendar year from a fiscal year, and eliminated the updates for calendar years 2006-2009. MMA also established that a revised payment system for surgical services furnished in an ASC will be implemented on or after January 1, 2006, and not later than January 1, 2008. Total payments under the new system should be equal to the total projected payments under the old system. As established by the TRHCA, starting in CY2009, the annual increase for ASCs that do not submit required quality data may be the required update minus 2 percentage points. The reduction for not submitting quality data would apply for the applicable year only, and not for subsequent years.<br><br>Beginning in CY2010, the ASC conversion factor will be updated annually using the consumer price index for all urban consumers (CPI-U). The ASC update will include a productivity adjustment starting January 1, 2011. | In **CY2009**, the ASC conversion factor was established at $41.393, after budget neutrality adjustments.<br><br>The **CY2010** update of 1.2% is subject to a wage index budget neutrality adjustment of 0.9996. The CY2010 ASC conversion factor is $41.873. |

## Table 17. Hospital Outpatient Services

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Hospital Outpatient Departments (HOPDs) | Under HOPD-PPS, which was implemented in August 2000, the unit of payment is the individual service or procedure as assigned to one of about 570 ambulatory payment classifications (APCs). To the extent possible, integral services and items are bundled within each APC, specified new technologies are assigned to new technology APCs until clinical and cost data is available to permit assignment into a clinical APC. Medicare's payment for HOPD services is calculated by multiplying the relative weight associated with an APC by a conversion factor. For most APCs, 60% of the conversion factor is geographically adjusted by the IPPS wage index. Except for new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. Certain APCs with significant fluctuations in their relative weights will have the calculated change dampened. The HOPD-PPS also includes budget-neutral pass-through payments for new technology and budget-neutral outlier payments. Cancer and children's hospitals have a permanent hold harmless protection from the HOPD-PPS. HOPDs in rural hospitals with 100 or fewer beds (that are not SCHs) will receive at least 85% of the payment it would have received under the prior payment system during CY2010. Starting for services on January 1, 2006, rural SCHs will receive a 7.1% payment increase. All SCHs receive 85% of the payment difference for covered HOPD services furnished during CY2010.<br><br>Over time, under Medicare's prior payment system, beneficiaries' share of total outpatient payments grew to 50%. HOPD-PPS slowly reduces the beneficiary's copayment for these services. Copayments will be frozen at 20% of the national median charge for the service in | The conversion factor is updated on a calendar year schedule. These annual updates are based on the hospital IPPS MB. As established by TRHCA, starting in CY2009, the update for hospitals that do not submit required quality data will be the MB minus 2 percentage points. The reduction for not submitting quality data would apply for the applicable year, and would not be taken into account in subsequent years. PPACA established a schedule of annual reductions in the update for starting CY2010 through CY2019. The CY2010 update reduction is 0.25 percentage points. The update will include a productivity adjustment starting January 1, 2012. The PPACA update reductions may result in a negative update for that year. | For **CY2009**, the update was 3.6%. Hospitals that fail to submit the required quality data I received an update of 1.6%. This increase was adjusted by budget-neutrality factors associated with wage index changes and pass through expenses. The final CY2009 conversion factor for hospitals that did submit the required quality data was $66.059 and was $64.784 for those that did not submit the required data.<br><br>For **CY2010**, the MB update is 2.1% which, as directed by PPACA, is reduced by 0.25 percentage points to result in an increase in 1.85%. Hospitals that did not submit required quality data receive a negative 0.15% update. This increase was adjusted by the required budget neutrality factors for wage index changes and pass-through expenses. The CY2010 conversion factor is $67.241 for hospitals that submit required quality data and $65.921 for hospitals that did not submit this data. (The prior year's update penalty for not submitting quality data is not taken into account in the next year.) |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| | 1996, updated to 1999. Over time, as PPS amounts rise, the frozen beneficiary copayments will decline as a share of the total payment until the beneficiary share is 20% of the Medicare fee schedule amount. A beneficiary copayment amount for a procedure is limited to the inpatient deductible amount established for that year. Balance billing is prohibited. | | |

## Table 18. Rural Health Clinics and Federally Qualified Health Center (FQHCs) Services

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Rural Health Clinics (RHCs) and Federally Qualified Health Center (FQHCs) services | RHCs and FQHCs are paid on the basis of an all-inclusive rate for each beneficiary visit for covered services. An interim payment is made to the RHC or FQHC based on estimates of allowable costs and number of visits; a reconciliation is made at the end of the year based on actual costs and visits. Per-visit payment limits are established for all RHCs (other than those in hospitals with fewer than 50 beds) and FHQCs. Assignment is mandatory; no deductible applies for FHQC services. | Payment limits are updated on January 1 of each year by the Medicare economic index (MEI) which measures inflation for certain medical services. | For **CY2009,** the RHC upper payment limit was $76.84, the urban FQHC limit was $119.29, and the rural FQHC limit was $102.58.<br>For **CY2010**, the RHC upper payment limit is $77.76, the urban FQHC limit is $125.72, and the rural FQHC limit is $108.81. |

## Table 19. Comprehensive Outpatient Rehabilitation Facility (CORF)

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

## Table 20. Part B Drugs and Biologicals Covered Incident to a Physician's Visit

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Drugs and biologics including vaccines. Medicare covers certain outpatient drugs and biologicals under the Part B program that are authorized by statute, including those: (1) that are covered if they are usually not self-administered and are provided incident to a physician's services; (2) those that are necessary for the effective use of covered DME; (3) certain self-administered oral cancer and anti-nausea drugs (those with injectable equivalents); (4) erythropoietin stimulating agents (ESAs) used to treat anemia; (5) immunosuppressive drugs after covered Medicare organ transplants; (6) hemophilia clotting factors; and (7) vaccines for influenza, pneumonia, and hepatitis B. | Drug products, except for pneumococcal, influenza, and hepatitis B vaccines, those associated with certain renal dialysis services, blood products and clotting factors and radiopharmaceuticals, are paid using the average sales price (ASP) methodology. The ASP for all drug products included within the same billing and payment code, usually the Healthcare Common Procedure Coding System (HCPCS) Code, is the volume-weighted average of the manufacturer's average sales prices reported to CMS across all the National Drug Codes (NDCs) assigned to the code. Medicare's payment under the ASP methodology equals 106% of the applicable price for a multiple source drug or single source drug subject to beneficiary deductible and coinsurance amounts. This is intended to cover both the acquisition cost of the drug and any administrative overhead resulting from procurement, storage, and administration of the drug. Regular Part B cost sharing applies, except for pneumococcal and influenza virus vaccines.<br><br>The MMA established a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Payment amounts for drugs furnished during the first year of an approved CAP vendor's contract are set through a competitive process using bidders' prices, which use the ASP payment amounts as a ceiling. To date, BioScrip was the only bidder to sign a contract under the CAP program, however the contract expired. | The ASP is updated quarterly by the Secretary. Payments under the ASP method may be lowered by the Secretary if the ASP exceeds the widely available market price or average manufacturer price by a specified percentage (5% in 2006 to present, as determined by the Secretary). In such cases, the payment would equal the lesser of the widely available market price or 103% of the average manufacturer price. Several OIG reports found that the percentage was exceeded for some drugs and the Secretary has chosen not to exercise the option of lowering the payment rate for these drugs.<br><br>CAP payments are updated on an annual basis based on the approved CAP vendor's reasonable net acquisition costs based, in part, on information disclosed to CMS and limited by the weighted payment amount established under section 1847A of the Social Security Act. Adjustment to the payment amounts may be made more often than annually, but no more often than quarterly, in any of the following cases: (1) Introduction of new drugs, (2) Expiration of a drug patent or availability of a generic drug, (3) Material shortage that results in a significant price increase for the drug, or (4) Withdrawal of a drug from the market. | According to the Centers for Medicare and Medicaid Services, the third quarter 2010 ASP payment amounts remain stable compared to the previous quarter. For most of the higher volume drugs (31 out of the top 50), the prices changed 2% or less. Overall, the prices for 13 of the top 50 drugs decreased, 2 remained the same, and 35 increased.<br><br>On September 10, 2008, the Centers for Medicare & Medicaid Services announced the postponement of CAP program due to their inability to establish contracts with any qualified bidders. |

## Table 21. Blood

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

## Table 22. Partial Hospitalization Services Connected to Treatment of Mental Illness

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

## Table 23. Ambulance Services

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Ambulance services | Ambulance services are paid on the basis of a national fee schedule, which is being phased-in. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. The ground ambulance categories are: basic life support (BLS), both emergency and nonemergency; advanced life support Level 1 (ALS1), both emergency and nonemergency; advanced life support Level 2 (ALS2); specialty care transport (SCT); and paramedic ALS intercept (PI). The air ambulance categories are: fixed wing air ambulance (FW) and rotary wing air ambulance (RW).<br>The national fee schedule is fully phased-in for air ambulance services. For ground ambulance services, payments through 2009 are equal to the greater of the national fee schedule or a blend of the national and regional fee schedule amounts. The portion of the blend based on national rates is 80% for 2007-2009. In 2010 and subsequently, the payments in all areas will be based on the national fee schedule amount. The payment for a service equals a base rate for the level of service plus payment for mileage. Geographic adjustments are made to a portion of the base rate. For ambulance services provided between July 1, 2008 and December 31, 2010, the fee schedule amounts are increased by 2% for services originating in urban areas and by 3% for services originating in rural areas. For the period July 1, 2004 to December 31, 2010, mileage payments are increased by 22.6% for ground ambulance services originating in rural, low population density areas. There is a 25% bonus on the mileage rate for trips of 51 miles and more from July 2004-December 2008. MIPPA and extended by PPACA specifies that any area designated as rural for the purposes of making | The fee schedule amounts are updated each year by the CPI-U for the 12 month period ending in June. The update is referred to as the ambulance inflation factor (AIF). | The CPI-U for the applicable period was -1.4%; Medicare set that the AIF for **2010** at 0.0%. The AIF for **2009** was 5.0%. |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| | payments for air ambulance services on December 31, 2006, will be treated as rural for the purpose of making air ambulance payments during the period July 1, 2008-December 31, 2010. Regular Part B cost sharing applies. Assignment is mandatory. | | |

# Parts A and B

**Table 24. Home Health**

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| Home health services | Home health agencies (HHAs) are paid under a prospective payment system that began in FY2001. Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits, medical supplies, and others. Durable medical equipment is not included in the home health (HH) PPS. The base payment amount is adjusted for: (1) differences in area wages using the hospital wage index; (2) differences in the care needs of patients (case mix) using "home health resource groups" (HHRGs); (3) outlier visits (for the extraordinarily costly patients); (4) a significant change in a beneficiary's condition (SCIC); (5) a partial episode for when a beneficiary transfers from one HHA to another during a 60-day episode; (6) budget neutrality; and (7) a low utilization payment adjustment (LUPA) for beneficiaries who receive four or fewer visits. There is no difference between urban and rural base payment amounts.<br><br>The HHRG applicable to a beneficiary is determined following an assessment of the patient's condition and care needs using the | The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the HH market basket (MB) index. This index measures changes in the costs of goods and services purchased by HHAs.<br><br>In CY2010, HHAs receive the full MB update. As specified in PPACA, the MB updates will be reduced by 1.0% for all HHAs in CY2011 through CY2013. For CY2014, HHAs will receive the full MB. Starting in CY2015, the MB update will be subject to the productivity factor adjustment.<br><br>DRA specified that HHAs that submit health care quality data, as specified by the Secretary, receive a full MB increase; while HHAs that do not submit such data receive an update equivalent to the MB minus 2 percentage points. This requirement was applicable for CY2007 and each subsequent year.<br><br>In CY2008, refinements to the Medicare HH PPS included a reduction in the national standardized 60-day episode payment rate for 4 years (ending in FY2011) to account for | For **CY2009**, the HH MB update was 2.9% for HHAs that submitted the required quality data and 0.9% for those that do not. The CY2009 base payment amounts for 60-day episode were also adjusted downward by 2.75% as a result of case mix refinements.<br><br>For **CY2010,** the HH MB update is 2.0% for HHAs that submit the required quality data and 0% for HHAs that do not. The CY2010 base payment amounts for 60-day episodes were also adjusted downward by 2.75% as a result of case mix refinements.<br><br>For visits ending on or after **April 1, 2010,** and before **January 1, 2016**, HHAs serving rural areas will receive a 3% add-on payment. |

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| | Outcome and Assessment Information Set (OASIS). After the assessment, a beneficiary is categorized in one of 80 HHRGs that reflect the beneficiary's clinical severity, functional status, and service requirements.<br><br>Starting in CY2010, outlier payments are capped at 10% of total payments per HHA, and no more than 2.5% of total aggregate PPS payments for all Medicare HH payments.<br><br>HHAs are paid 60% of the case-mix and wage-adjusted payment after submitting a request for anticipated payment (RAP). The RAP may be submitted at the beginning of a beneficiary's care once the HHA has received verbal orders from the beneficiary's physician and the assessment is completed. The remaining payment is made when the beneficiary's care is completed or the 60-day episode ends. | changes in case mix that are not related to home health patients' actual clinical conditions; among other things. This resulted in a payment downward for a 60-day episode of care of 2.75% for CY2008 through CY2010, and 2.71% for CY2011.<br><br>According to PPACA, starting in CY2014, the Secretary is required to rebase HH payments by a percentage considered appropriate by the Secretary to, among other things, reflect the number, mix and level of intensity of HH services in an episode, and the average cost of providing care. Any adjustments that result must be made before the annual payment updates are applied for that year (see next column regarding MB updates). A four-year phase-in, ending in 2017, will be implemented, in equal increments, each increment may not exceed 3.5% of the HH PPS base payment amount as of March 23, 2010. PPACA also requires the Secretary to reduce the standard HHRG amounts such that the aggregate reduction in payments will equal 5% of total PPS payments for a period. | |

## Table 25. End-Stage Renal Disease Dialysis Services

| Provider/service | General payment policy | General update policy | Recent update |
|---|---|---|---|
| End-stage renal disease (ESRD) | ESRD is a condition of permanent kidney failure, that must be treated either with a kidney transplant or by dialysis. Because of the scarcity of available kidneys for transplant, dialysis is the treatment option for most ESRD beneficiaries. Dialysis treatment removed excess fluid and toxins from the patient's blood. Dialysis services involve several procedures and prescription drugs necessary to fully treat ESRD.<br><br>Dialysis services are offered in three outpatient settings: hospital-based facilities, independent facilities, and the patient's home. There are two payment methods. Under Method I, facilities are paid a prospectively set amount, known as the composite rate, for each dialysis session, regardless of whether services are provided at the facility or in the patient's home. The composite rate is derived from audited cost data and adjusted for the national proportion of patients dialyzing at home versus in a facility, and for area wage differences. Beneficiaries electing home dialysis may choose not to be associated with a facility and may make independent arrangements with a supplier for equipment, supplies, and support services. Payment to these suppliers, known as Method II, is made on the basis of reasonable charges, limited to 100% of the median hospital composite rate, except for patients on continuous cycling peritoneal dialysis, when the limit is 130% of the median hospital composite rate. Assignment is mandatory; regular Part B cost sharing applies. Kidney transplantation services, to the extent they are inpatient hospital services, are subject to the PPS. However, kidney acquisition costs are paid on a reasonable cost basis.<br><br>MMA required the Secretary to establish a basic | MMA provided for an update to the composite rate beginning January 1, 2005. Since April 1, 2005 the composite rate has been case-mixed adjusted, budget neutrally. The Secretary was required to update the basic wage-adjusted case-mix payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate.<br><br>MIPPA changed the payment increases for the composite rate in 2009 and 2010.<br><br>As required by MIPPA, estimated Medicare total dialysis payments for 2011 will equal 98% of payments that would have been made if the bundled payment system had not been implemented.<br><br>Per MIPPA, beginning in 2012, the Secretary will annually increase the bundled payment amounts by an ESRD market basket increase factor appropriate for a bundled payment system for renal dialysis minus 1 percentage point. However, PPACA amended this provision so that the market basket will no longer be subject to a 1 percentage point reduction beginning in 2012, but will be subject to the productivity factor adjustments instead.<br><br>Beginning in January 1, 2012, providers of renal dialysis services and renal dialysis facilities will be subject to quality incentive requirements and they will be subject to a reduction of up to 2% if they do not meet the requirements. | For **CY2009**, the composite rate was increased by 1% to $133.81 for both hospital-based facilities and independent facilities. The drug add-on adjustment to the composite rate payment was $20.33 per treatment. The wage index adjustment for 2009 reflected the latest available wage date, including a revised budget neutrality adjustment of 1.056672. The ESRD wage index floor was reduced from .75 to .70. Beginning in 2009, wage adjustments will be based on 100% of the Core-Based Statistical Area geographic adjustments.<br><br>The composite rate for dialysis services furnished in **CY2010** increased by 1% over the December 31, 2009 amount, resulting in a composite rate of $135.15 for both hospital-based and independent facilities services furnished on or after January 1, 2010. The drug add-on adjustment for 2010 remained the same as the 2009 adjustment, at $20.33 per treatment. The wage index adjustment for 2010 reflects the latest available wage date, including a revised budget neutrality adjustment of 1.057888. The ESRD wage index floor was reduced from .70 to .65. |

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| | case-mix adjusted prospective payment system for dialysis services furnished either at a facility or in a patient's home, for services furnished beginning on January 1, 2005. The basic case-mix adjusted system has two components: (1) the composite rate, which covers services, including dialysis; and (2) a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General Reports.<br><br>MIPPA changed payments for dialysis. Beginning January 1, 2009, the payment rate for dialysis services are "site neutral" and in applying the geographic index to providers of services, the labor share is based on the labor share otherwise applied for renal dialysis facilities. Adjustments are no longer made to the composite rate for hospital-based dialysis facilities to reflect higher overhead costs.<br><br>MIPPA requires the Secretary to implement a bundled payment system, making a single payment for Medicare renal dialysis services, beginning January 1, 2011. The bundled payment will include items and services which were included in the composite rate as of December 31, 2010, erythropoiesis stimulating agents (ESAs) and other drugs and biologicals paid for separately (before bundling), and diagnostic laboratory tests among other items. It will not include vaccines.<br><br>Payments will include adjustments for case mix, high cost outliers (including variations in the amount of ESAs), and costs in rural, low-volume facilities (with a minimum payment adjustment of 10% for services furnished between January 1, 2011, and January 1, 2014), among others.<br><br>The bundled payments system will be phased-in equally (and budget neutrally) over four years. It will be fully implemented by January 1, 2014. | | |

# Part C

## Table 26. Managed Care Organizations

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| (a) Medicare advantage contracts | In general, Medicare makes a monthly payment in advance to participating Medicare Advantage (MA) health plans for each enrolled beneficiary in a payment area. In exchange, the plans agree to furnish all Medicare-covered items and services (except hospice) to each enrollee. In general, the actuarial value of basic cost sharing may not exceed the actuarial value of cost sharing under original Medicare.<br><br>Congress made substantial changes to the Medicare+Choice program with the passage of the MMA in 2003. The act created the Medicare Advantage (MA) program, which replaced the M+C program and introduced several changes designed to increase the availability of private plans for Medicare beneficiaries. In addition to the immediate payment increases to plans, beginning in 2006 the MA program changed the payment structure and introduced regional plans that operate like Preferred Provider Organizations. Additionally, beneficiaries had access to a drug plan whether they were enrolled in original Medicare or a private plan.<br><br>In 2006, the Secretary began determining MA plan payments by comparing plan *bids* to a *benchmark*. A plan's bid is its estimated revenue requirement of providing Part A and B Medicare services to beneficiaries (including cost of services, administration, and profit). A benchmark is the maximum amount CMS will pay a plan for providing these required benefits. If a plan's bid is less than the benchmark, its payment is equal to its bid plus a rebate equal to a percentage of the difference between its | The MA payments are determined annually by the method described under "General Payment Policy."<br><br>For CY2004 through CY2009, plan benchmarks were updated annually by the minimum percentage increase, or in certain years, 100% of FFS spending in the area (the rebased amount). The minimum percentage increase is the prior year's benchmark increased by the national MA growth percentage (*projected increase in Medicare per capita expenditures*). In years when the Secretary rebases rates, the benchmark for each county was updated by the greater of either the national MA growth percentage, or 100% of FFS spending adjusted to exclude the value of Medicare direct medical education payments, as explained below. Beginning in 2004 and at a minimum every third year, the Secretary is required to rebase FFS payment rates. Rebasing is updating FFS rates to reflect recent growth in county health care expenditures.<br><br>The update to the benchmark for regional plans has both a statutory increase and a competitive increase. The statutory component is similar to the update for other MA plans and the competitive component is based on a weighted average of plan bids.<br><br>DRA made additional changes to the benchmark calculation. Beginning in 2007, DRA added two new adjustments to calculating the benchmark: (1) an adjustment to exclude budget neutrality in risk adjustment, and (2) an adjustment to account for coding intensity | For **CY2009**, MA benchmarks were updated by the greater of either 100% FFS spending, or the previous year's benchmark increased by the national MA growth percentage (4.24%) adjusted for budget neutrality (1.009)—an increase of 3.6%..<br><br>For **CY2010**, MA benchmarks were not rebased. All benchmarks were updated by the increase in the national MA growth percentage (0.81%), adjusted for budget neutrality (1.001), and the phase-out of indirect medical education (a maximum reduction of approximately 0.6%).<br><br>Also for CY2010, a uniform 3.4% reduction will be applied to the risk scores of all MA plan enrollees to account for differences in coding patterns between MA plans and providers under Parts A and B of original Medicare.<br><br>As required by PPACA, the MA benchmarks for **CY2011** are the same as the benchmarks in CY2010.<br><br>For CY2011, a uniform 3.41% reduction will be applied to the risk scores of all MA plan enrollees to account for diagnosis coding intensity differences between MA plans and providers under original Medicare. |

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| | bid and the benchmark. (Before 2012, the rebate is equal to 75%; starting in 2012, the size of the rebate is contingent of plan quality, as explained below.) The remaining amount is retained by the federal government. If a plan's bid is greater than the benchmark, its payment is equal to the benchmark amount and the plan must make up the difference between its bid and the benchmark by charging a beneficiary premium. In general, the Secretary has the authority to review and negotiate plan bid amounts to ensure that the bid reflects revenue requirements. At least one plan offered by an MA organization must be an MA-PD plan, one that offers Part D prescription drug coverage. MA organizations offering prescription drug coverage receive a direct subsidy for each enrollee in their MA-PD plan, equal to the plan's risk adjusted standardized bid amount (reduced by the base beneficiary premium). The plans also receive a reinsurance payment amount for the federal share of their payment as well as premium and cost-sharing reimbursements for qualified low-income enrollees.<br><br>Also beginning in 2006, the MA program began offering regional plans covering both in- and out-of-network required Medicare services. To encourage regional plan participation in the program additional payments were authorized in certain circumstances for hospitals that would not otherwise join a private plan's network.<br><br>Beginning in 2012, for MA plans that bid below the benchmark, the rebate will be contingent on plan quality as measured by a 5-star quality rating system established by the Secretary. The calculation will be phased in over three years from 75% for all MA plans that bid below the benchmark for years prior to 2012, to a rate of 70% for plans with a star rating of 4.5 or higher, | differences between MA plans and original Medicare for years 2007 through 2010. For purposes of calculating the phase-out of budget neutrality in risk adjustment, the Secretary was required to conduct a study of the difference between treatment and coding patterns between MA plans and providers under Parts A and B of Medicare. The findings were to be incorporated into calculations of MA benchmarks in 2008, 2009, and 2010, however they were first incorporated in 2010.<br><br>Beginning in 2010, MIPPA requires that the value of indirect medical education be phased-out of all benchmarks. The amount phased-out each year will be based on a ratio of (1) a specified percentage (0.60% in the first year), relative to (2) the proportion of per capita costs in original Medicare in the county that IME costs represent. The effect of the ratio is to phase-out a higher proportion of IME costs in areas where IME makes up a smaller percentage of per capita spending in original Medicare. After 2010, the numerator of the phase-out percentage will be increased by 0.60 percentage points each year.<br><br>CY2011 benchmarks will be frozen at the CY2010 level.<br><br>Starting in CY2012, benchmarks will begin to be calculated as a percent of a base rate. In CY2012, the base rate will equal 100% FFS spending in the area and will be updated each year. County benchmarks will be set at either 95%, 100%, 107.5% or 115% of the base rate, with higher percentages applied to counties with the lowest FFS spending. The phase-in will take place over 2 to 6 years, with a larger phase-in period for areas where the new methodology would result in larger benchmark decreases.<br><br>The yearly update to the base rate will either | |

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| | 65% for plans with a star rating of 3.5 or greater, but below 4.5 stars, and 50% for plans with less than 3.5 stars. The rebate based on plan quality will be fully phased-in by 2014. | be a rebased amount for all counties, or an increase above the previous years' base equal to the national MA growth percentage for all counties. Also starting in CY2012, benchmarks will be increased based on plan quality with higher increases in qualifying areas. The coding intensity adjustment first specified in DRA will continue after CY2010 with specified minimum adjustments starting in CY2014. | |
| (b) Cost contracts | Medicare pays cost contract health maintenance organizations (HMOs) and competitive medical plans (CMPs) the actual costs they incur for furnishing Medicare-covered services (less the estimated value of required Medicare cost sharing), subject to a test of "reasonableness." Interim payment is made to the HMO/CMP on a monthly per capita basis; final payment reconciles interim payments to actual costs.<br><br>Beginning January 1, 2013, cost contracts can not be extended or renewed in a service area if, during the entire previous year, the service area had two or more MA regional plans or two or more MA local plans offered by different organizations. | No specific update. Cost-based HMOs are paid 100% of their actual costs. | No specific update. |

# Part D

**Table 27. Outpatient Prescription Drug Coverage**

| Provider/service | General payment policy | General update policy | Recent update |
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| **Part D drug coverage**. Outpatient prescription drug coverage is provided through private prescription drug plans (PDPs) or MA prescription drug (MA-PD) plans. The program relies on these private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies cover the bulk of the risk. Unlike other Medicare services, the benefits can only be obtained through private plans. While all plans have to meet certain minimum requirements, there are significant differences among them in terms of benefit design, beneficiary premiums amounts, drugs included on plan formularies (i.e. list of covered drugs) and | Federal payments to plans are linked to "standard coverage." Qualified Part D plans are required to offer either "standard coverage" or alternative coverage, with at least actuarially equivalent benefits. For 2010, most plans offer actuarially equivalent benefits or enhanced coverage rather than the standard package. A number of plans have reduced or eliminated the deductible. Many plans offer tiered cost sharing under which lower cost sharing applies for generic drugs, higher cost sharing applies for preferred brand name drugs, and even higher cost sharing applies for non-preferred brand name drugs. Some plans provide some coverage in the coverage gap ("doughnut hole"); this is generally limited to generic drugs. | The definition of standard coverage is updated annually based on the estimated increase in per capita costs for the 12 month period ending the previous July. | In **CY2010**, "standard coverage" has a $310 deductible and 25% coinsurance for costs between $310 and $2,830 (the initial coverage period). From this point, there is no coverage, except for a $250 Medicare rebate mandated by recent legislation, until the beneficiary has out-of-pocket costs of $4,550 ($6,440 in total spending); this coverage gap has been labeled the "doughnut hole." Once the beneficiary reaches the catastrophic limit, the program pays all costs except for nominal cost sharing.<br><br>PPACA, as amended by HCERA, mandates phasing out the Part D doughnut hole. Beginning in 2011, manufacturers will be required to provide a 50% discount on brand-name drugs to participate in the Part D program. The law phases in Medicare coverage for generic drugs during the coverage gap starting in 2011, and for brand name drugs in 2013. When the doughnut hole is fully phased out in 2020, Part D enrollees will be responsible for 25% of the cost of brand name and generic drugs during the coverage gap (the same as in the initial coverage phase). The catastrophic coverage limit will also be reduced to a small extent in years 2014 through 2019. |

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| cost sharing applicable for particular drugs. Drug prices under Part D are determined through negotiations between the PDPs, or MA-PDs, and drug manufacturers. The Secretary of Health and Human Services is statutorily prohibited from intervening in Part D drug price negotiations. | | | |
| **Federal Subsidy Payments** | Federal subsidy payments (including both direct payments and reinsurance payments) are made to plans consistent with an overall subsidy level of 74.5% for basic coverage. Direct monthly per capita payments are made to a plan equal to the plan's standardized bid amount adjusted for health status and risk and reduced by the base beneficiary premium, as adjusted to reflect the difference between the bid and the national average bid. Reinsurance payments, equal to 80% of allowable costs, are provided for enrollees whose costs exceed the annual out-of-pocket threshold ($4,550 in 2010). | Payments to plans are calculated annually by the method described under "General Payment Policy." | Federal payments were recalculated for the 2010 plan year. |
| **Beneficiary Premiums** | Beneficiary premiums represent on average 25.5% of the cost of the basic benefit. A base beneficiary premium is calculated based on the national average monthly bid amount for basic coverage. This amount is then adjusted, up or down as appropriate, to reflect differences between the plan's standardized bid amount and the national average monthly bid amount. It is further increased for any supplemental benefits and decreased if the individual is entitled to a low-income subsidy. The premium is the same for all individuals in a particular plan | Beneficiary premiums are calculated annually by the method described under "General Payment Policy." | Beneficiary premiums were recalculated for the 2010 plan year. The base beneficiary premium for 2010 is $31.94. (Actual premiums paid by individual beneficiaries vary from one Part D plan to another.) |

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| | (except those entitled to a low income subsidy). | | |
| **Risk corridors** | The federal government and plans share the risk for costs within specified "risk corridors."Risk corridors" are specified percentages for costs above and below a target amount; the target amount is defined as total payments paid to the plan taking into account the amount paid to the plan by the government and enrollees. | In 2006 and 2007, plans were at full risk for costs within 2.5% above or below the target. If costs were between 2.5% and 5% above the target, they were at risk for 25% of spending between 2.5% and 5% of the target and 20% of spending above that amount. If plans fell below the target, they have to refund 75% of the savings if costs fall between 2.5% and 5% below the target and 80% of any amounts below 5% of the target. For 2008-2011, risk corridors are modified. Plans are at full risk for spending within 5% above or below the target. They are at risk for 50% of spending between 5% and 10% of the target and 20% of any spending exceeding 10% of the target. | The 2010 risk corridors are modified, as described under "General Update Policy." |

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