APPENDIX A

How Medicare pays for services: an overview

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

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

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

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

Recent legislation—the Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)—fundamentally changed the way Medicare pays for many products and services. These laws required the Centers for Medicare & Medicaid Services (CMS)[3] to develop and adopt new prospective payment systems (PPSs) for services furnished by skilled nursing facilities, hospital outpatient departments, home health agencies, rehabilitation facilities, long-term care hospitals, and psychiatric facilities. The legislation also required CMS to change the method for

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

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

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

making prospective capitation payments to health care organizations under the M+C program. In addition, CMS has modified its PPSs for hospital inpatient acute care, physician services, and ambulance services, and proposed changing its payment methods for durable medical equipment.

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

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

Key structural elements of Medicare's prospective payment systems

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

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

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

To set and maintain accurate payment rates for many products and services—even in a single setting—is a difficult task. At a minimum, policymakers need the following conditions (Table A-1, p. 222):

- The products and services Medicare is buying must be well defined.
- The relative costliness of each product or service compared with that of the average service unit must be measurable.
- Production processes used by providers must be understood well enough to identify the major inputs that contribute to efficient providers' unit costs.
- Patient or beneficiary characteristics and market circumstances that may affect providers' costs must be known and measurable.
- A payment update method must be developed to adjust payment rates annually, consistent with changes in input prices and other factors that may affect efficient providers' costs over time.

Defining the products and services Medicare is buying

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

Consistent with the unit of payment, the classification system identifies distinct services, types of patient care products, or patients who are expected to require different amounts of resources. In some Medicare payment systems—the hospital inpatient PPS, for example—the classification categories reflect different clinical problems and treatment strategies as indicated by diagnoses and procedures. In others, such as those for physician, hospital outpatient, or ambulatory surgical services, the categories reflect different procedures or evaluation and management services. In all payment systems, the classification categories define the products for which Medicare will pay.

Setting relative values

Relative values measure the expected costliness of a unit in each classification category compared with the expected average costliness of all units. Categories

that require more resources than average have higher relative values, and those that require fewer resources have lower ones. Relative values are often referred to as case-mix weights.

Setting a national base payment rate

The base payment rate represents the amount Medicare would pay for an average unit of service in a market with national average input prices, if no other payment adjustments applied. The base payment rate in each setting should reflect the costs the payment rates are intended to cover—operating costs alone or operating and capital costs together.[4] Base payment amounts per unit are sometimes called conversion factors as in the physician fee schedule or the hospital outpatient PPS.

In some of Medicare's payment systems—those for hospital inpatient, outpatient, skilled nursing, or home health services, for instance—the Congress has required CMS to set national base payment amounts to reflect national average historical costs for the affected providers. In general, average historical unit costs in the base year have been updated to the first payment year by taking into account industry-wide inflation and changes in case mix during the intervening years. In some instances, however (the physician fee schedule, for example) measures of providers' historical costs are simply not available. In these cases, the initial base payment amounts often have been set so that total projected payments in the first year under any new payment system would equal total projected payments under the preceding system for the same year.

Adjusting for local market conditions

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

Other adjustments

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

Updating payment rates

Payment rates for most settings must be updated annually to reflect changes in technology, practice patterns, and market conditions. Thus CMS must develop methods and data sources to be used in updating the base payment amount, the product classification system, and the relative values. Other payment adjustments also may need periodic revision as conditions change. In most payment systems, the national base payment rate is updated annually to reflect the forecasted increase in an industry-specific national input-price index called a market basket (MB) index. The MB index, developed by CMS, tracks national average price levels for labor and other inputs, weighted to reflect the relative importance of each input category in the specific industry.[5] This update affects all payment rates equally, so it does not affect the distribution of payments among product categories or across providers.

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

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

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

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

TABLE A-1

Summary of Medicare's current payment systems by setting

	Acute inpatient care		Ambulatory care				Post-acute care	
Payment system description	**Acute care hospitals**	**Psychiatric facilities**	**Physicians**	**Hospital outpatient departments**	**Ambulatory surgical centers**	**Outpatient laboratories**	**Skilled nursing facilities**	**Home health agencies**
Fiscal year began	1984	1983	1992	2000	1982	1984	1998	2001
Basis of payment	Prospective	Facility costs with limit	Prospective	Prospective	Prospective	Prospective	Prospective	Prospective
Product definition								
Unit of payment	Discharge	Discharge	Service	Service	Procedure	Test	Day	60-day episode
Product classification system	509 DRGs	None	7,000+ HCPCS codes	HCPCS grouped in 570 APCs	HCPCS in 8 procedure groups	1,100+ HCPCS codes	44 RUG–III groups	80 HHRGs
Policies defining product boundaries	72-hour rule short-stay transfers; high-cost outliers	None	Differentials by setting, multiple or atypical services	High-cost outliers; multiple service discount	Multiple service discount	None	None	Fewer than 5 visits; high-cost outliers
Product relative values								
Components of relative values	Single value for each DRG	None	Physician work; practice expenses; liability insurance	Single value for each APC	Single amount for each group	Combined with base amount	Therapy services; nursing care	Single value for each HHRG
Source of relative values	Hospitals' billed charges	None	Expert judgement; practice expense data; premium survey	Median of estimated service costs	Median of estimated service costs	None	Staff-time studies	Estimated mean cost per HHRG
Base payment rate/conversion factor								
Components of base amount	Labor-related; nonlabor; capital	Current per unit operating costs	Single conversion factor (for sum of relative values)	Labor-related; other	Labor-related; other	Carrier-specific rates with limit	Therapy; nursing care; routine care	Labor-related, other
Source of base amount	Updated providers' 1982 costs	Facility's annual cost report	Projected spending under preceding method	Updated 1996 OPD charges adjusted to costs	1986 survey of ASCs' costs and charges	Updated 1983 lab charges	Target aggregate spending	Spending in preceding system

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pay different amounts for the same service, depending on the setting in which it is furnished.

The remainder of this appendix describes how the key elements are combined for each of the 15 payment systems Medicare uses to pay providers for services they furnish to its beneficiaries.

Acute inpatient services

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

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

Payment for acute care services in short-term general hospitals

Each year, about one of every five Medicare beneficiaries enrolled in the traditional program has one or more inpatient stays in a short-term acute care

TABLE A-1

Summary of Medicare's current payment systems by setting

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

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Note: APC (ambulatory payment classification), ASC (ambulatory surgery center), BLS (Bureau of Labor Statistics), CAH (critical access hospital), CMG (case-mix group), COLA (cost of living adjustment applied in Alaska and Hawaii), CPI–U (consumer price index for all urban consumers), CPT (Current Procedural Terminology), DRG (diagnosis related group), DSH (disproportionate share), GME (graduate medical education), FFS (fee-for-service), GPCI (geographic practice cost index), HCPCS (Healthcare Common Procedure Coding System), HHRG (home health resource group), HWIr (hospital wage index with geographic reclassifications), HWIu (hospital wage index without geographic reclassifications), LTC (long-term care), OPD (outpatient department), PE (practice expense), PLI (professional liability insurance), RUG–III (resource utilization group, version III), SGR (sustainable growth rate), SNF (skilled nursing facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

hospital.[6] They receive care in more than 4,800 facilities that contract with Medicare to provide services and agree to accept the program's predetermined payment rates as payment in full.[7] Payments for inpatient care (about $94 billion in 2001) account for the largest component—about 34 percent—of Medicare spending. These payments also provide the largest single source of hospitals' revenues—about 23 percent of overall revenues.

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

6 The Medicare inpatient hospital benefit covers beneficiaries for 90 days of care per illness episode, with a 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted for care and end after they have been out of the hospital or a skilled nursing facility for 60 consecutive days. Beneficiaries are liable for a deductible of $840 for the first hospital stay in an episode. Daily copayments—currently $210—are imposed beginning on the 61st day.

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

TABLE A-1

Summary of Medicare's current payment systems by setting

Payment system description	Post-acute care: Inpatient rehabilitation facilities	Post-acute care: Long-term care hospitals	Services for special populations: Outpatient dialysis care	Services for special populations: Hospice services	Other services: Ambulance services	Other services: Durable medical equipment	Medicare+Choice plans
Fiscal year began	2002	2003	1982	1983	2002	1986	1998
Basis of payment	Prospective	Prospective	Prospective	Prospective	Prospective	Prospective	Prospective
Product definition							
Unit of payment	Discharge	Discharge	Dialysis treatment	Day	Trip	Item	Month
Product classification system	385 CMGs	499 LTC–DRGs	None	4 care type groups	14 HCPCS within 9 service levels, 2 CPT codes	HCPCS within 6 equipment categories	Beneficiaries' demographics and health risk
Policies defining product boundaries	Short-stay outliers/deaths; transfers; high-cost outliers	Short-stay outliers; transfers; high-cost outliers	None	Beneficiary gives up curative treatment	Base rate and mileage	None	All-inclusive capitation payment rate
Product relative values							
Components of relative values	Single value for each CMG	Single value for each LTC–DRG	None	Combined with base amounts	Single value for each service level	Combined with base amounts	One value for each enrollee category
Source of relative values	Hospitals' billed charges	Hospitals' billed charges	None	None	Negotiated rulemaking	None	FFS bills 1990–1995
Base payment rate/conversion factor							
Components of base amount	Labor-related; other	Labor related; other	Labor-related; other	Labor-related; other	Single conversion factor for base rate	Single amount	Updated 2001 rate; blended national/ county rate
Source of base amount	Projected spending under preceding method	Projected spending under preceding method	1977–1979 cost reports	Cost data from Medicare demonstration	Projected spending under preceding method	Allowed charges in 1986–1987	Historical FFS spending in county and nation

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hospitals predetermined per-discharge rates that are based primarily on two factors:

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

Using information about patients' diagnoses, procedures, age, and discharge destination reported on hospitals' claims, Medicare assigns discharges to diagnosis related groups (DRGs), which group patients who have similar clinical problems and are expected to require similar amounts of hospital resources. Each DRG has a national relative weight that reflects the expected relative costliness of inpatient treatment for a patient in that group compared with that for the average Medicare patient. Groups expected to require more resources than average have higher weights, and those expected to require fewer resources have lower ones.

The payment rates for DRGs in each local market are determined by adjusting a national average base payment amount (the amount that would be paid for an average patient in a facility located in an average market) to reflect the input-price level in the local market, and then multiplying the adjusted local amount by the relative weight for each DRG. Payment rates also are increased for facilities that operate approved physician (resident) training programs, those that

TABLE A-1

Summary of Medicare's current payment systems by setting

	Post-acute care		Services for special populations		Other services		
Payment system description	**Inpatient rehabilitation facilities**	**Long-term care hospitals**	**Outpatient dialysis care**	**Hospice services**	**Ambulance services**	**Durable medical equipment**	**Medicare+Choice plans**
Adjustments for local market conditions							
Labor input prices	Hospital wage index (HWIu)	Hospital wage index (HWIu)	40% 1986 HWI+ 60% 1980 BLS wage index	Hospice wage index	PE GPCI for physician fee schedule	Carrier-specific rates with limit	Hospital wage index (HWIu); GPCIs
Other input prices	None	COLA	None	None	None	None	None
Other payment adjustments	Low-income patients	None	Higher rates for hospital-based facilities	None	Rural and low-volume add-ons	Product-specific national limits	Floor rates
Payment update method	Rise in modified TEFRA market basket index	Rise in modified TEFRA market basket index	No routine update	Rise in hospital market basket index	Rise in CPI–U	Rise in CPI–U	Rise in aggregate FFS spending; 2 percent minimum
Payments for capital costs	Included in prospective rates	Included in prospective rates	Included in payment rate	Included in payment rate	Included in payment rate	Included in payment rate	Included in payment rate
Other policies	Higher rates in rural areas	None	Exceptions; extra payments for some tests and drugs	Annual payment per beneficiary capped	Qualifying CAHs on cost-based reimbursement	None	None

Note: APC (ambulatory payment classification), ASC (ambulatory surgery center), BLS (Bureau of Labor Statistics), CAH (critical access hospital), CMG (case-mix group), COLA (cost of living adjustment applied in Alaska and Hawaii), CPI–U (consumer price index for all urban consumers), CPT (Current Procedural Terminology), DRG (diagnosis related group), DSH (disproportionate share), GME (graduate medical education), FFS (fee-for-service), GPCI (geographic practice cost index), HCPCS (Healthcare Common Procedure Coding System), HHRG (home health resource group), HWIr (hospital wage index with geographic reclassifications), HWIu (hospital wage index without geographic reclassifications), LTC (long-term care), OPD (outpatient department), PE (practice expense), PLI (professional liability insurance), RUG–III (resource utilization group, version III), SGR (sustainable growth rate), SNF (skilled nursing facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

treat a disproportionate share of low-income patients, and for other factors.

Because the inpatient PPS accounts for a large share of Medicare spending, it faces ongoing scrutiny, often leading to technical and policy improvements. The PPS payment rates are intended to cover the costs that reasonably efficient providers would incur in furnishing high quality care, thereby rewarding those whose costs fall below the payment rates. However, financial performance under the PPS differs substantially among certain groups of hospitals. Some of these differences represent intended effects of policies adopted by the Congress. In other instances, they may reflect unintended results of inaccurate or inappropriate payment adjustments, and failures to address factors that affect efficient providers' costs in certain circumstances.

Defining the hospital inpatient acute care products Medicare buys

Under the inpatient PPS, Medicare sets per-discharge payment rates for distinct treatment episodes represented by 508 DRGs, which are based on patients' clinical conditions and treatment strategies.[8] Clinical conditions are described by patients' discharge diagnoses, including the principal diagnosis—the main problem requiring inpatient care—and up to eight secondary diagnoses indicating other conditions that were present at admission (comorbidities) or developed during the hospital stay (complications). The treatment strategy—surgical or medical treatment—is described by the presence or absence of up to six procedures performed during the stay. Age, sex, and discharge destination—for example, home, another PPS hospital, or a skilled nursing

8 Although the federal DRG classification system includes 527 categories, 19 are no longer used for Medicare payment.

facility—are also occasionally used to distinguish groups of patients who are expected to use different amounts of resources.

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

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

In return for receiving Medicare's predetermined payments, hospitals are expected to furnish a reasonably well-defined bundle of inpatient services for each DRG. Facing fixed payment rates, however, providers have financial incentives to reduce their inpatient costs by moving some normally included services to another setting—such as an outpatient department or a skilled nursing facility—and bill those services separately. To counter these financial incentives, Medicare has adopted policies that help strengthen the boundaries of the inpatient service bundles associated with the DRGs. Thus, patients must stay overnight before their discharges qualify for payment under the inpatient PPS. Related outpatient department services that were delivered in the three days before admission are included in the payment for the inpatient stay and may not be separately billed (the 72-hour rule). Similarly, payments for services may be reduced when patients are transferred to another hospital after a stay that is more than one day shorter than the national average stay for the DRG. The same payment reductions apply for certain DRGs when patients are transferred to post-acute care facilities, such as rehabilitation or skilled nursing facilities, or discharged to receive clinically related home health care that begins within three days.

Setting the payment rates

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

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

The base payment amounts Medicare sets two separate operating base payment amounts (known as standardized payment amounts): one for large urban areas—metropolitan statistical areas (MSAs) with a population of one million or more—and one for all other urban and rural areas.[12] These base payment amounts represent what a hospital located in these areas would be paid for operating expenses for an average Medicare patient (before any adjustments). The base operating amounts per discharge for FY 2003 are $4,251 for large urban areas and $4,184 for other areas.

Capital payments have only recently been made fully prospective, having completed a 10-year phase-in during FY 2001.[13] The base capital rate for discharges from hospitals in large urban areas for FY 2003 is $419; it is $407 for hospitals located in other areas.

The diagnosis related group relative weights Medicare assigns a weight to each DRG reflecting the average relative costliness of cases in that group compared with that for the average Medicare case. The same DRG weights are used to set operating and capital payment rates. CMS recalibrates the DRG weights annually

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

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

11 Certain costs are excluded from the inpatient PPS and paid separately, such as direct costs of operating graduate medical education programs, organ acquisition costs, and bad debts related to beneficiaries' nonpayment of their cost-sharing liabilities (deductibles and copayments).

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

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

based on average standardized billed charges for all PPS cases in each DRG in the most recent Medicare bill file.[14]

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

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

Other adjustments Payment rates also may be adjusted to reflect higher costs of care in hospitals that operate approved resident training programs, revenue losses associated with treating low-income patients, and the financial burden of exceptionally high-cost cases. These adjustments are intended to preserve access to care for Medicare beneficiaries by protecting hospitals that face certain cost or revenue pressures.[16] Medicare also makes special payments to several groups of hospitals.[17] Most of these special payment provisions are designed to help rural hospitals, although some urban facilities also may qualify.

Indirect medical education payments
Teaching hospitals receive add-on payments to reflect the additional (indirect) costs of patient care associated with operating approved physician training programs. The size of the indirect medical education (IME) adjustment applied to DRG payments depends on the hospital's teaching intensity, as measured by the number of residents per bed. In 2001, approximately 1,100 hospitals received IME payments.

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

Until 2001, small urban hospitals—those with fewer than 100 beds—and most rural providers had to meet substantially higher minimum low-income patient shares to qualify for DSH payments. The BIPA reduced the qualifying thresholds for small urban and rural providers to the same level applied for larger urban hospitals. In 2001, these policy changes expanded eligibility for DSH payments from about 1,800 hospitals to about 2,800 hospitals; about 800 of the newly eligible facilities were in rural areas.

Outlier payments In general, hospitals are expected to offset losses on some cases (in which costs exceed the payment rate) with gains on others (in which costs are below payments). Some cases, however, are extraordinarily costly, producing losses that may be too large to offset. Hospitals facing fixed payment rates have strong financial incentives to avoid patients who may be likely to require extraordinary care. To promote access to high-quality inpatient care for seriously ill beneficiaries, Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital DRG payments. Outlier cases are identified by comparing their costs to a DRG-specific threshold that is the sum of the hospital's DRG payment for the case (both operating and capital), any IME and DSH payments, and a fixed loss amount. For instance, in 2003

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

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

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

17 These special payment provisions are discussed in greater detail in MedPAC's June 2001 Report to the Congress: Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. Washington (DC), MedPAC. June 2001.

the threshold is set at the hospital's DRG payment plus any IME and DSH payments plus $33,560—the national fixed loss amount—adjusted to reflect input price levels in the hospital's local market. Medicare pays 80 percent of hospitals' costs above their fixed loss thresholds. Costs for individual cases are estimated by reducing the hospital's covered charges for the case by its overall Medicare cost-to-charge ratio from its most recent settled annual cost report. IME and DSH adjustments are not applied to outlier payments. Outlier payments are funded by offsetting reductions in the operating base payment amounts (5.1 percent) and the capital federal rate (5.3 percent).

Transfer policy Medicare reduces DRG payments when the patient is transferred to another PPS hospital, or in some instances to a post-acute care setting. When a patient is transferred to another PPS hospital, the transferring facility is paid a per diem amount for each day before the transfer occurs, up to a maximum of the full DRG payment.[18] The hospital receiving a transferred patient is paid as if the case had not been transferred.[19] Beginning in FY 1999, discharges in 10 DRGs are treated as transfers if patients are sent to a long-term care hospital or a rehabilitation, psychiatric, or skilled nursing facility, or they receive clinically related home health care. This policy is intended to strengthen the boundaries of the hospital inpatient service bundle by reducing providers' financial incentives to unbundle services normally furnished during the hospital inpatient stay. The 10 affected DRGs were selected by the Secretary of HHS based on their high volume and disproportionately high likelihood of post-acute care use. The Secretary was authorized to expand the set of DRGs to which this policy applies beginning in FY 2001, but has not yet done so.

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

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

Payment for specialty psychiatric facilities

Medicare beneficiaries with mental illnesses or alcohol- and drug-related problems are frequently treated in specialty psychiatric facilities, either freestanding hospitals or specialized hospital-based units. These hospitals generally furnish short-term acute care. To be admitted to a specialty facility, patients generally must be considered a risk to themselves or others.[20] Payments to psychiatric facilities (almost $3 billion in 2001) represent only a small part of total Medicare spending (about 1 percent), but the program accounts for about 30 percent of psychiatric facilities' annual revenues.

Psychiatric facilities are paid for furnishing care to Medicare beneficiaries under cost growth limits established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); payments are based on their incurred average operating costs per discharge, subject to an annually adjusted facility-specific limit (see text box).

The Congress required CMS to develop and implement a per diem PPS to replace the earlier payment methods; CMS plans to implement the new system in 2003.

As is the case for stays in short-term acute care hospitals, beneficiaries treated in specialty psychiatric facilities are responsible for a deductible—$840 in 2003—for the first admission during a spell of illness, and for a copayment—$210 per day—for the 61st through 90th days. Beneficiaries treated for psychiatric conditions in specialty facilities also are covered for 90 days of care per illness episode, with a 60-day lifetime reserve.[21] Over their lifetimes, however, beneficiaries are limited to 190 days of treatment in freestanding psychiatric hospitals.

Ambulatory care

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

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

These physicians and providers furnish a wide range of services, including some

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

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

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

21 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$420 per day in 2003.

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

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

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

Because facilities' operating targets were based on their own historical costs, TEFRA payments often varied substantially among facilities. In addition, new providers often entered the Medicare program with higher costs than older providers had, giving new providers higher targets and creating payment inequities. The Congress required the Centers for Medicare & Medicaid Services (CMS) to design PPSs for the three largest classes of facilities—rehabilitation facilities, long-term hospitals, and psychiatric facilities. Rehabilitation facilities began payment under a PPS in January 2002; long-term care hospitals began payment under a PPS in October 2002. Speciality psychiatric facilities will continue to be paid under TEFRA until a PPS for this group is implemented.

To reduce inequities in target amounts, the Balanced Budget Act of 1997 (BBA) established temporary national caps on facilities' target amounts from 1998 through 2002 for three provider groups: long-term care hospitals and rehabilitation and psychiatric facilities. (Cancer and children's hospitals continued to be paid under the old TEFRA method during this period.) In addition, the BBA temporarily reduced capial payments for all TEFRA facilities to 85 percent of their allowable capital costs. Beginning in 2003, these provisions expired and facilities returned to the old TEFRA payment method.

However, the BBA also established two permanent features in the TEFRA payment system. One is payment limitations for new specialty facilities excluded from the acute care hospital PPS on or after October 1, 1997. The other is revised incentive payments for facilities with costs below their targets and relief payments for facilities with costs above their targets.

Facilities' operating targets are updated according to a TEFRA market basket. The market basket index for FY 2003 is 3.5 percent. ■

common to more than one setting. For example, beneficiaries may receive identical services in physicians' offices and hospital outpatient departments. Outpatient laboratory services help physicians in offices and outpatient departments to diagnose, treat, and monitor patients' illnesses or conditions. Some ambulatory surgeries can be performed in physicians' offices, outpatient departments, or ambulatory surgical centers.

Payment for physician services

Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. These services are furnished in all settings, including physicians' offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Medicare payments to physicians (about $56 billion in 2001) account for about 20 percent of total spending.

The Medicare physician payment system was implemented in 1992. To make predetermined payments for physician services, Medicare uses a fee schedule with payment rates for more than 7,000 services. Many services have two payment rates: a higher rate for services provided in nonfacility settings, such as physicians' offices, and a lower rate for

those furnished in facilities, such as hospitals. Rates are lower for services furnished in facilities because physicians' practice costs are generally lower. Also, when a service is provided in a facility, Medicare pays both the facility and the physician.

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

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

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

The physician fee schedule was adopted more than 10 years ago, but efforts to improve it continue. For example, CMS is working with the physician community to refine the relative weights for practice expenses.

Defining the physician services that Medicare buys

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

Setting the payment rates

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

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

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

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

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

Fourth, payments are adjusted downward when services are furnished by physicians who are not in Medicare's participating physician and supplier program. Payment rates for services provided by nonparticipating physicians are 95 percent of the fee schedule payment rate.

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

The annual updates for the conversion factor are made according to the SGR system. If actual spending is less than the target, the update is greater than the change in input prices for physician services. If actual spending is greater than

the target, the update is less than the change in input prices.

Payment for outpatient hospital care

Medicare beneficiaries receive a wide range of services in hospital outpatient departments, from injections to surgical procedures requiring general anesthesia. Spending for these services is growing rapidly, largely because of changes in technology and medical practice that have fostered new services and encouraged shifts in care from inpatient to ambulatory care settings. Outpatient hospital care accounted for about 7 percent of total Medicare spending in 2001, or about $16 billion.[22]

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

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

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

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

Defining the outpatient hospital products that Medicare buys

Medicare pays for outpatient services based on the individual service or procedure provided, as identified by an HCPCS code. CMS classified procedures, evaluation and management services, and drugs and devices furnished in outpatient departments into about 570 ambulatory payment classifications (APCs). These APCs group items and services that are clinically similar and use comparable amounts of resources. More than 300 of the APCs identify drugs or devices used in conjunction with a procedure. In addition, some new services are assigned to certain "new technology" APCs based only on similarity of resource use. CMS chose to establish new technology APCs because some services were too new to be represented in the data used to develop the outpatient PPS. Services remain in these APCs for two to three years while CMS collects the clinical and cost data necessary to refine and update the APC classification system. Additional services may be placed in the new technology APCs after review by CMS.

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

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

Setting the payment rates

Payment rates in the outpatient PPS are intended to cover hospitals' operating and capital costs for the facility services they furnish; professional services (physicians' services provided to individual patients, for example) are paid separately. Outpatient payment rates are determined by multiplying the relative weight for an APC by a conversion factor. Except for the new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. Services are assigned to a new technology APC based on their expected cost. New technology APCs range from $0–$50 to $5,000–$6,000, with an additional category at $19,500–$20,500; the relative weights are set at the midpoint of these ranges.

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

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

22 Total spending on all hospital outpatient services (those covered by the outpatient PPS as well as those paid under separate fee schedules or based on costs) accounted for $18.4 billion in 2001.

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

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

Outlier payments are made for individual services or procedures that have extraordinarily high costs, compared with the payment rates for their APC group. In 2003, outliers are defined as services with estimated costs that exceed a threshold equal to 2.75 times the PPS payment rate. Hospitals will be reimbursed for 45 percent of the difference between the threshold and the estimated cost of the service in 2002. Aggregate outlier payments are limited to 2 percent of total payments; outlier payments are financed by reducing the conversion factor by 2 percent.

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

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

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

CMS also annually updates the conversion factor by the projected increase in hospital market basket index unless the Congress stipulates otherwise.

Payment for care provided by ambulatory surgical centers

Since 1982, Medicare has paid for the facility costs of surgical procedures provided in freestanding or hospital owned and operated ambulatory surgical centers (ASCs). ASCs are distinct facilities that furnish only ambulatory surgery; the most common procedures are cataract removal and lens replacement, other eye procedures, and colonoscopy. Payments to ASCs (about $1.6 billion in 2001) account for less than 1 percent of total Medicare spending.

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

Defining the care that Medicare buys from ambulatory surgical centers

The unit of payment in the ASC payment system is the individual surgical procedure. Each of the 2,300 procedures approved for payment in an ASC is classified into one of nine payment groups.

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

and less than 4 hours of recovery room time.

Setting the payment rates

To set ASC payment rates, CMS must survey a sample of ASCs every five years to collect data on their costs and charges for individual procedures. After auditing the survey data, CMS adjusts ASCs' charges to reflect costs using cost-to-charge ratios. CMS sets the national payment rate for each of the nine payment groups equal to the estimated median cost of procedures in that group. To account for geographic differences in market input prices, CMS adjusts the labor portion of the rate using the hospital wage index for the ASC's location. The labor portion of the rate is currently 34.45 percent.[23] ASC payment rates also are adjusted when multiple surgical procedures are performed during the same operative session. In this case, the ASC receives full payment only for the procedure with the highest payment rate; payments for the other procedures are reduced to one-half of their usual rates.

Between revisions to the payment system, the ASC payment rates are to be updated annually based on the CPI–U. The BBA limited those updates to the CPI–U minus 2 percentage points (but not less than zero) from FY 1998 through FY 2002. CMS also is required by law to update every two years the list of procedures performed in ASCs that are eligible for Medicare payment.

Payment for outpatient laboratory services

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

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

Defining the laboratory products Medicare buys

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

Setting the payment rates

The fee schedule payment rates represent the total payment to laboratories; beneficiary copayments are not required. CMS assigns payment amounts for all laboratory HCPCS codes in each carrier market based upon 1983 charges from the laboratories in that market. Medicare payments were set at the 60th percentile of prevailing charges for freestanding laboratories and the 62nd percentile for hospital-based laboratories in each area. In 1987, fees for outpatient services in hospital laboratories, other than those performed in sole community hospitals, were reduced to the 60th percentile of prevailing charges. Fee schedule amounts differ from carrier to carrier in some instances, but no separate geographic adjustment is provided. Beginning in 1986, the Congress established upper limits on laboratory payment rates, called national limitation amounts (NLAs). NLAs are based on the median of all carrier rates for each test. The NLAs have been repeatedly reduced and currently are set at 74 percent of the median of all local fee schedule amounts for each procedure. Because so many of the carrier payment rates are constrained by the NLAs, most laboratory services are paid the same national rate.

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

Post-acute care

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

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

Most patients use this care immediately following an acute hospital stay.

Payment for skilled nursing facility services

Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing

23 The labor-related portion of the rate was determined by calculating the average percentage of facility costs attributable to labor expenses for the 90 facilities included in the 1986 cost survey. The 1994 cost survey—which has not been used to update payment rates—showed that 37.66 percent of facility costs were related to labor expenses.

facilities (SNFs). SNFs can be hospital-based units or freestanding facilities. About 1.4 million beneficiaries use SNF care in a year, but Medicare's payments for these services account for only about 10 percent of freestanding nursing facilities' revenues; they make up less than 2 percent of hospitals' revenues. Similarly, payments to SNFs ($15.3 billion in 2001) represent only about 6.5 percent of total Medicare spending.

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

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

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

The SNF PPS has problems characterizing and classifying patient days, thereby raising questions about its ability to generate payments that accurately reflect efficient providers' costs of furnishing care. Partly in response to this problem, the Congress temporarily increased payments to SNFs. Two of the three payment increases expired at the end of FY 2002.

The skilled nursing facility product Medicare buys

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

Setting the payment rates

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

The rates are adjusted to account for differences in input prices among local markets. The labor-related portion of the daily payment rate—75 percent for FY 2002—is multiplied by the hospital wage index in the SNF's location, and the result is added to the nonlabor portion. Rates are updated annually, based on the projected increase in the SNF market basket index, a measure of the national average price level for the goods and services SNFs purchase to provide care.

The initial payment rates in 1998 were set to reflect the projected amount that SNFs received in 1995, updated for inflation.[24] The Congress subsequently increased the payment rates temporarily in several ways:

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

Payment for home health care services

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

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

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

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

About 2.2 million beneficiaries used home health care in 2001. Medicare's payments to HHAs were about $9 to $10 billion[25] in 2000, accounting for around 6 percent of total Medicare spending but a large share of HHAs' total revenues.

Until October 2000, HHAs generally were paid on the basis of their incurred average costs per visit, subject to annually adjusted limits. In October 2000, CMS adopted a new PPS in which HHAs are paid a predetermined rate for each 60-day episode of home health care. The payment rates are based on patients' conditions and service use, and they are adjusted to reflect the level of market input prices in the geographical area where services are delivered. If fewer than 5 visits are delivered during a 60-day episode, the HHA is paid per visit by visit type, rather than by the episode payment method. Adjustments for several other special circumstances, such as high-cost outliers, can also modify the payment. Payment rates also are increased for patients in rural areas.

Setting rates for Medicare home health services has always been complicated by the lack of a clear definition of the benefit. The benefit was originally intended for short-term, posthospital recovery care for beneficiaries who could not leave their homes, but changes to eligibility criteria have expanded the benefit. Beneficiaries who have no preceding hospital stay and are capable of spending significant time outside their homes are now eligible to receive covered services furnished in an unlimited number of home care episodes.

The home health products Medicare buys

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

Setting the payment rates

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

The initial national average base payment amount for a typical home health episode in 2001 was set so that projected spending would equal the amount that would have been spent under the previous payment system. This amount was reduced beginning in 2003 to account for certain previously deferred payment reductions. Further, because providers receive payments on a per-visit basis for patients who are furnished fewer than 5 visits in 60 days, the base amount was adjusted to reflect this policy. It was also reduced 5 percent to account for anticipated high-cost outlier payments. For FY 2003, the national average payment rates for HHRGs range from $1,000 to $6,000.

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

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

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

The base rate is updated annually. The update is based on the projected change in the home health market basket index, which measures changes in the prices of goods and services home health agencies must buy to produce care.

Payment for inpatient services in rehabilitation facilities

After an illness, injury, or surgical care, some patients need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. Relatively few beneficiaries use intensive rehabilitation therapy because they must be able to tolerate and benefit from three hours of therapy per day to be eligible for treatment in an inpatient rehabilitation setting. Among those who qualify, many are admitted to inpatient rehabilitation

25 Estimates vary.

facilities (IRFs), which may be freestanding hospitals or specialized, hospital-based units. Others may receive care in a SNF, especially in markets that lack IRFs or have few rehabilitation beds. Although payments to IRFs (about $4.2 billion in 2001) represent only a small part of total Medicare spending (about 1 percent), Medicare accounts for a large share of IRF revenues.

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

Defining the inpatient rehabilitation products Medicare buys

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

Setting the payment rates

The PPS payment rates are intended to cover all operating and capital costs that efficient facilities would be expected to incur in furnishing covered rehabilitation services. The initial payment level (base rate) for a typical discharge—$12,193 for FY 2003—is intended to reflect the projected amount providers would have been expected to receive per discharge under the previous payment system (TEFRA) in 2003. Because providers will receive additional payments under the PPS for extraordinarily costly patients (high-cost outliers), the projected amount is reduced (3 percent) to maintain the same expected total spending. Further, reflecting its experience with similar financial incentives under other discharge-based PPSs, CMS decreased the base rate (by 1.16 percent) in the expectation that providers would lower their costs by reducing lengths of stay compared with those under TEFRA.

The base rate is adjusted to account for differences in input prices among markets. The labor-related portion of the base payment amount—72 percent—is multiplied by a version of the hospital wage index, and the result is added to the nonlabor portion. The adjusted rate for each market is multiplied by the relative weights for all CMGs to create local PPS payment rates. Payment rates are increased for IRFs located in rural markets and for those that treat low-income patients. Rural facilities' payment rates are increased by 19 percent to compensate for their tendencies to have fewer cases, longer lengths of stay, and higher average costs per case. An IRF also is eligible to receive higher payment rates if it serves at least one low-income patient. The payment adjustment for each facility is based on its low-income patient share, which is the sum of two proportions: the proportion of total inpatient days furnished to beneficiaries eligible for Supplemental Security Income benefits and the proportion of total patient days furnished to Medicaid patients. After adjustments for local market conditions, rural location, and type of treatment category, the CMG payment rates range from $3,819 to $58,590.

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

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

Payment for services furnished in long-term care hospitals

Patients with clinically complex problems, such as multiple acute or chronic conditions, may need hospital care for relatively extended periods of time. Some are admitted to long-term care hospitals (LTCHs). Other patients—especially in the many markets without these hospitals—may be cared for in acute care hospitals or SNFs. Payments to LTCHs (about $2 billion in 2001) represent only a small part of total Medicare spending (less than 1 percent); however, Medicare accounts for a substantial proportion of these hospitals' revenues.

Beginning in October 2002, LTCHs are paid predetermined per-discharge rates

based primarily on the patient's diagnosis and market conditions in the facility's location.[26] Before then, LTCHs were paid for furnishing care to Medicare beneficiaries under TEFRA.

Discharges are assigned to case-mix categories containing patients with similar clinical problems that are expected to require similar amounts of resources. Each case-mix category has a national relative weight reflecting the expected relative costliness of treatment for a patient in that category compared with that for the average Medicare LTCH patient. The payment rates for case-mix categories in each local market are determined by adjusting a national average base payment amount to reflect the input-price level in the local market, and then multiplying the adjusted local amount by the relative weight for each case-mix group. Payment rates also are increased for hospitals located in Alaska and Hawaii and for cases that are extraordinarily costly. Payment rates are adjusted for patients who have very short stays and for those who are transferred to an acute care hospital, an inpatient rehabilitation facility, or a skilled nursing facility for a specified amount of time, followed by readmission to the same LTCH.

Defining the long-term care hospital products Medicare buys

Under the PPS for care in LTCHs, Medicare sets payment rates for 499 types of treatment episodes. These episodes are called long-term care diagnosis related groups (LTC–DRGs). The grouping system for episodes is the same one used for the acute care hospital PPS. Patients are assigned to these treatment categories based on the discharge diagnosis, including the principal diagnosis; up to eight secondary diagnoses; up to six procedures performed; age; sex; and discharge status. LTCHs may receive partial payments for patients who do not receive a full course of treatment.

Setting the payment rates

The PPS payment rates are intended to cover all operating and capital costs that efficient LTCHs would be expected to incur in furnishing covered acute long-term care services. The initial payment level (base rate) for a typical discharge—$34,956 for FY 2003—is intended to reflect the projected amount providers would have been expected to receive per discharge under the previous payment system in FY 2003. Because providers will receive additional payments under the PPS for extraordinarily costly patients (high-cost outliers), the projected amount is reduced (8 percent) to maintain the same expected total spending. Further, reflecting its experience with similar financial incentives under other discharge-based PPSs, CMS decreased the base rate (by 0.34 percent) in the expectation that providers would lower their costs by reducing lengths of stay compared with those under the old payment system.

The base rate is adjusted to account for differences in input prices among markets. This adjustment is being phased in over five years. The labor-related portion of the base payment amount—73 percent—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion.[27] For LTCHs in Alaska and Hawaii, the nonlabor portion is adjusted by a COLA and added to the labor-related portion.[28] The adjusted rate for each market is multiplied by the relative weights for all LTC–DRGs to create local PPS payment rates.

Relative weights for the LTC–DRGs differ from the acute care hospital DRG weights. Medicare assigns a weight to each LTC–DRG reflecting the average relative costliness of cases in the group compared with that for the average Medicare case. LTC–DRGs with fewer than 25 cases in 2001 have been grouped into 5 categories based on their average charges; relative weights for these 5 case-mix groups have been determined based on the average charges for the LTC–DRGs in each of these 5 groups.

LTCHs are paid adjusted PPS rates for patients who do not receive a full course of treatment. Short-stay outliers are defined as cases with a length of stay up to and including five-sixths of the geometric average length of stay for the LTC–DRG. For short-stay outliers, LTCHs are paid the least of:

- 120 percent of the cost of the case,
- 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay for that case, or
- the full LTC–DRG payment.

LTCHs are paid adjusted PPS rates for patients who are extraordinarily costly. High-cost outlier cases are identified by comparing their costs to a LTC–DRG-specific threshold that reflects the DRG payment for the case plus a fixed loss amount. For example, in 2003 the threshold is set at the LTC–DRG payment plus $24,450—the national fixed loss amount—adjusted to reflect the input price levels in the local market. Medicare pays 80 percent of the LTCHs' costs above their fixed loss thresholds. High-cost outlier payments are funded by offsetting reductions in the base payment amount (8 percent).

LTCHs receive one payment for patients who are transferred from the LTCH to another facility for a specified period of time and return to the LTCH—so-called "interrupted stays." Interrupted stays are defined as those cases in which an LTCH

26 LTCHs began receiving payments under the new PPS at the beginning of their FY 2003 cost reporting periods. During a five-year transition period, they are paid a blend of the PPS rate and their updated facility-specific rate. For example, in the first year of PPS, payments will be made up of 20 percent PPS rates and 80 percent facility-specific rates; in the second year, payments will be made up of 40 percent PPS rates and 60 percent facility-specific rates.

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

28 The COLA reflects the higher costs of supplies and other nonlabor resources in Alaska and Hawaii; it increases the nonlabor portion of the payment by as much as 25 percent.

patient is discharged to an inpatient acute care hospital, an IRF, or a SNF for a specified period followed by readmission to the same LTCH. The specified period of time for an interrupted stay is 9 days when the patient is discharged to an acute care hospital, 27 days for discharge to an IRF, and 45 days for discharge to a SNF. PPS payment is based on the LTC–DRG assigned to the case at discharge to the other facility.

Finally, Medicare has established policies to discourage transfers between LTCHs and other providers, followed by readmissions to the LTCH, when the LTCH and any of the other providers are located in the same facility or on the same campus (colocated). Medicare's concern about such transfers is that they may occur as a result of financial instead of clinical considerations. Within a cost reporting period, Medicare treats transfers to co-located acute care hospitals followed by readmissions to the same LTCHs above a threshold of 5 percent of all cases as if they were one LTCH discharge for payment purposes. Until the threshold is exceeded, Medicare treats each case as a discharge. A separate 5 percent threshold applies to cases transferred to colocated SNFs, IRFs, and psychiatric facilities.

Services for special populations

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

- outpatient dialysis facilities
- hospices

Payment for outpatient dialysis services

Individuals with ESRD—irreversible loss of kidney function—require either dialysis or kidney transplantation to survive. In 1972, the Social Security Act extended all Medicare Part A and Part B benefits to individuals with ESRD who are entitled to receive Social Security benefits. This entitlement is nearly universal, covering 93 percent of all people with ESRD in the United States. Total Medicare spending for these beneficiaries has outstripped expectations—reaching about $15 billion in 2001—primarily because of unanticipated growth in the ESRD population. The 350,000 enrolled ESRD beneficiaries in 2001 accounted for 0.8 percent of total Medicare enrollment, compared with only 0.1 percent of enrollment in 1974. This enrollment growth reflects population aging and improvements in clinical knowledge and technique that have enabled successful treatment of older patients and those with coexisting illnesses who might not have been treated 30 years ago.

Because of the scarcity of kidneys available for transplantation, most people with ESRD receive dialysis treatments three times per week in either freestanding or hospital-based facilities. Medicare spending for outpatient dialysis and injectable drugs administered during dialysis (about $6.7 billion in 2001) accounts for 2 percent of total program expenditures but is a predominant share of revenues for dialysis facilities. Medicare pays dialysis facilities a predetermined amount for each dialysis treatment they furnish, using a payment system first implemented in 1983. The prospective payment—called the composite rate—is intended to cover the bundle of services, tests, drugs, and supplies routinely required for dialysis treatment and is adjusted only to account for differences in local input prices.

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

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

A draft of this study is currently being reviewed within CMS.

Defining the dialysis products Medicare buys

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

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

Providers may separately bill Medicare for certain injectable medications, including erythropoietin and vitamin D analogues, and laboratory tests that are not included in the composite rate bundle. The Congress has set the payment for erythropoietin at $10 per 1,000 units whether it is administered intravenously or subcutaneously in dialysis facilities or in patients' homes. Providers receive 95

percent of the average wholesale price for separately billable injectable medications other than erythropoietin administered during in-center treatments. Finally, providers furnishing laboratory services outside the composite rate bundle are paid according to the laboratory fee schedule.

Setting the payment rates

The composite rate is intended to cover all operating and capital costs that efficient providers would incur in furnishing dialysis treatment episodes in dialysis facilities or in patients' homes. The base payment rate is $131 for hospital-based facilities and $127 for freestanding facilities in 2002. Medicare caps its payments to facilities at an amount equal to three dialysis sessions per week, although dialysis may be given more frequently.

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

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

Dialysis facilities are reimbursed for bad debt that results when, after a good faith effort, they are unable to collect beneficiaries' 20 percent coinsurance amounts for dialysis services.

Payment for hospice services

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

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

To be eligible for hospice services, beneficiaries must give up other covered services related to curative treatment of the terminal condition, although Medicare still pays for unrelated care. Twenty percent of Medicare beneficiaries who died in 1998 used hospice care. Payments to hospices (almost $3.4 billion in 2001) represent a small part of total Medicare spending (about 1 percent), although Medicare makes up a large share of hospice revenues.

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

Defining the hospice products Medicare buys and setting payment rates

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

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

A hospice's annual aggregate payments are limited by a capped amount ($17,391 for FY 2003) multiplied by the number of beneficiaries newly enrolled during the year. The capped amount is updated annually by the consumer price index for all urban consumers, U.S. city average (CPI–U).

Other services

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

- ambulance services.
- durable medical equipment.

Payment for ambulance services

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

Ambulance providers are either facility based (hospital, skilled nursing facility, or home health agency) or freestanding suppliers, a distinction integral to past and current payment. Until April 1, 2002, Medicare based payments for ambulance services on providers' reported costs (facility-based providers) and charges (freestanding providers). Providers were paid a base rate, which covered the costs of services and supplies, and a mileage payment. This approach provided few incentives for cost containment and often resulted in payment and coverage disparities among similar providers. These issues, together with increased expenditures, led the Congress to mandate in the BBA that CMS implement a prospective fee schedule.

Several issues delayed fee schedule adoption, including how to adjust for higher costs incurred by low-volume providers, how to ensure that aggregate payments to ambulances were not reduced, and whether to require additional coding to document the medical necessity of services. After a fairly extensive rule-making period, including the formation and guidance of an advisory committee for CMS, the final rule was issued in February 2002 for implementation effective April 1, 2002.

Defining the ambulance product Medicare buys

Under the new prospective fee schedule, 14 HCPCS codes are used to distinguish the level of services provided, supplies and equipment used, and mileage. Ambulance suppliers may also bill two CPT codes for electrocardiograms. Ambulance-administered drugs are considered supplies and are not reimbursed separately. Payments are reduced when a beneficiary dies before the ambulance arrives at the scene.

CMS adopted nine transport service levels from the National Emergency Medical Services Training Blueprint as revised by the Department of Transportation. When different from the Blueprint, state and local laws preempt the Blueprint for vehicle staffing and clinical certification requirements. CMS assigned relative value units for seven of the service levels (ground only) through negotiated rule-making with the advisory committee.

Setting the payment rates

The new fee schedule establishes payment amounts that, for ground or water services, are the product of a nationally uniform relative value for the service, a geographic area adjustment factor, and a nationally uniform conversion factor. The conversion factor is based on four estimates for 2002 through 2006: spending levels (both program and beneficiary), inflation, the mix of service levels performed, and the increase in Medicare enrollment. If these behavioral and other assumptions prove different, CMS will adjust the conversion factor prospectively, in order to keep the total amount of payments in the system equal to the level prior to fee schedule implementation. For air services, the base payment is the product of an unadjusted nationally uniform value for the service and a geographic adjustment; there is no conversion factor or relative value unit.

The geographic adjustment accounts for varying costs of conducting business in different regions of the country, and is equal to the geographic practice expense index for the Medicare physician fee schedule. The geographic areas are those used for the physician fee schedule, selected by location of the patient when put on the ambulance. The geographic index applies to 70 percent of the base rate for ground services and 50 percent of the base rate for air services; it does not apply to the mileage payment rate.

A separately calculated payment is made for mileage to account for costs attributable to use of the ambulance vehicle. To reflect cost differences, mileage rates vary between ground and air transport and also distinguish between fixed wing and rotary wing (helicopter) transport. For rural ground trips, CMS provides a 50 percent add-on to the mileage rate for the first 17 miles and a 25 percent add-on for miles 18 through 50, as established in BIPA. Rural air trips receive a 50 percent add-on to the base rate and to all of the miles from the time a patient is placed on board.

The ambulance fee schedule will be phased in through a five-year transition period of blended payments. For April through December 2002, providers were paid 80 percent by the former method and 20 percent according to the new fee schedule. For 2003, the percentage has changed to 60 percent by the former method and 40 percent according to the new fee schedule. By 2006 payments will be 100 percent according to the new fee schedule.

The conversion factor, the air ambulance base rates, and the mileage rates will be updated annually based on the rise in CPI–U. However, during the rule-making process, BIPA mandated an update of 4.7 percent for services furnished between July 1, 2001, and December 31, 2001, 2 percentage points higher than the CPI–U.

The fee schedule applies to all entities providing services and they must accept the fee schedule amount as payment in full. Critical access hospitals that have no other ambulance service provider or supplier within a 35-mile driving distance are the sole exception; they receive cost-based reimbursement.

Payment for durable medical equipment

When medical equipment is needed to treat a beneficiary's illness or injury at

home, it is covered under the durable medical equipment (DME) benefit. Medicare spent about $7 billion on DME in 2001, about 3 percent of fee-for-service program spending.

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

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

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

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

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

The durable medical equipment Medicare buys

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

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

Within the 6 categories, equipment is further categorized into about 2,000 product groups. Examples of product groups are high-strength, lightweight wheelchairs and rental portable oxygen systems. All items within the same product group have the same payment rate.

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

The BBA gave Medicare the authority to apply a so-called test of inherent reasonability to some items that have well-developed retail markets; this allows CMS some price-setting flexibility. CMS has also conducted a competitive bidding demonstration to test the effects of competition on prices for certain DME items. In three phases of the demonstration, competitive bidding lowered prices for selected DME items 17 percent, 21 percent, and 22 percent.

Setting the payment rates

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

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

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

Medicare+Choice plans

Medicare beneficiaries may choose to receive their Medicare benefits from a private plan participating in the Medicare+Choice program rather than from the traditional program. Under some M+C plans, beneficiaries may receive benefits beyond those offered under traditional Medicare and may pay additional premiums. Medicare pays plans a capitated rate for the 12 percent of beneficiaries currently enrolled. These payments amounted to $37 billion in 2002, 15 percent of total Medicare spending.

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

In response to concerns that plans could not survive in areas with low payment rates (because of historically low per capita Medicare spending), the Congress set floors to raise the lowest rates.

Many analysts have been concerned that the current risk adjusters, based mostly on demographic variables, do not account for predictable differences in spending for covered services among beneficiaries. More accurate risk adjusters are being phased in.

Defining the Medicare+Choice products Medicare buys

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

Medicare's payment rates for a month of coverage are based on beneficiaries' counties of residence and on their relative expected cost, as predicted by demographic and diagnostic health factors. The county-level rates are determined administratively, based on statutory formulas. The 2003 rate for a county is the highest of three values:

- a floor rate of $548 for counties in metropolitan areas with 250,000 or more people, or $495 for all other counties;
- the county's 2001 rate increased by 2 percent; or
- a 50/50 blend of an input price-adjusted national average rate and an updated historical rate based on the county's 1997 payment rate.

All blended rates are adjusted by a budget neutrality factor that constrains national payments. For 2003, budget neutrality could not be achieved; thus, the blended rates were not applicable.

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

- age,
- sex,
- whether the beneficiary has ESRD,
- whether the beneficiary is also covered by Medicaid,
- whether the beneficiary is institutionalized,
- whether the beneficiary (or spouse) is currently covered as an active worker under an employer-sponsored plan, and
- a health risk factor currently based on diagnoses assigned when the beneficiary used certain Medicare-covered services during the preceding year.

Setting the payment rates

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

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

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