Basics of Medicare Coverage and Payment

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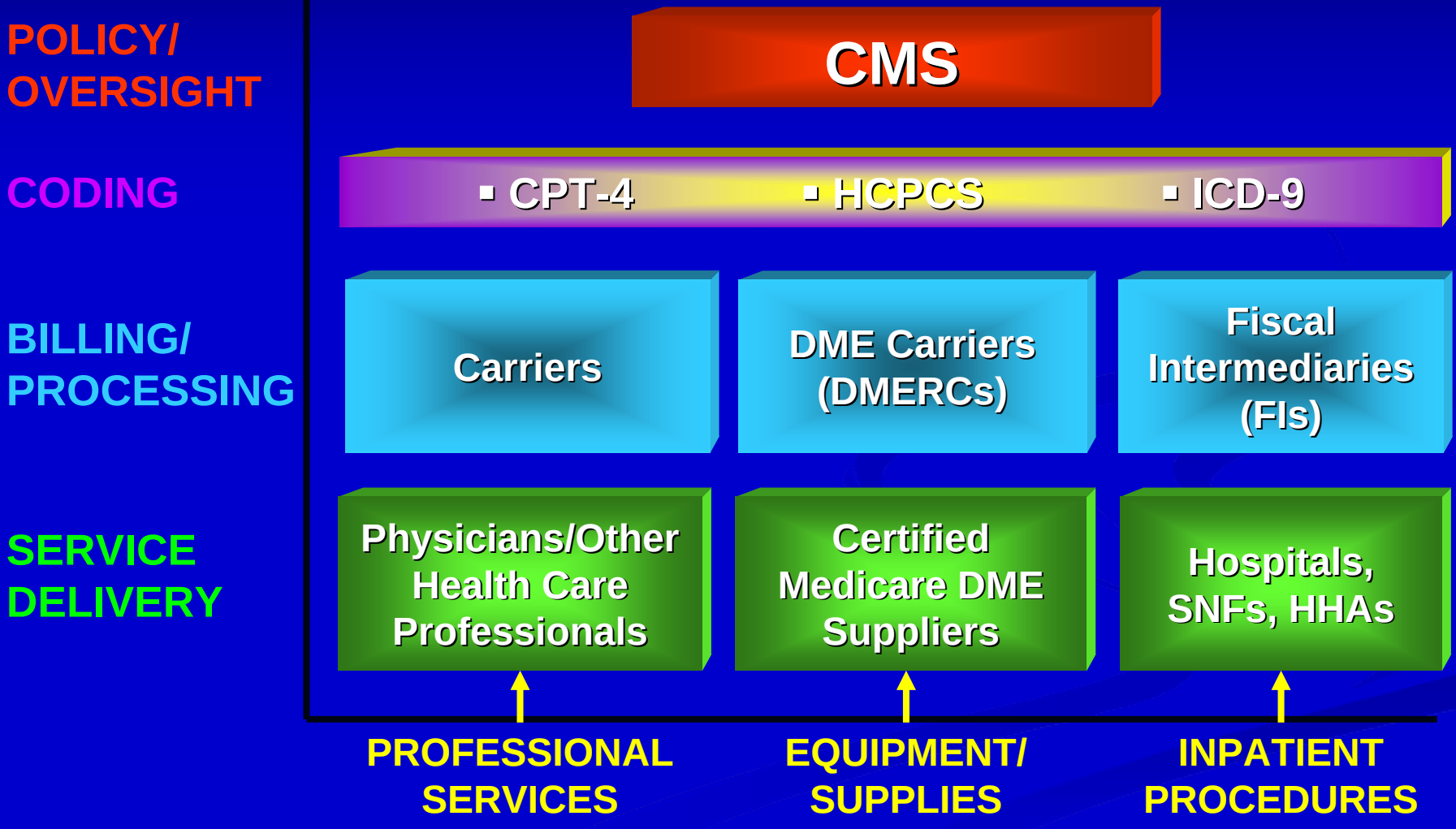
Two Pathways for Medicare Coverage Decisions

- National coverage decisions (NCDs)
  - Developed by CMS
  - Only 10% of covered items fall under an NCD
- Local coverage decisions (LCDs)
  - Developed by local Medicare contractors
  - Contractors for Parts A (FIs) + B (carriers) + DME (Regional DMERCs)

Medicare Fee-for-Service
(81% of Beneficiaries)



Payment Systems Vary by Type and Site of Service

Site/Type of Service	Payment Mechanism
Inpatient hospital PPS	DRGs
Outpatient hospital PPS	APCs
Skilled Nursing Facility PPS	Per Diem (case mix adjusted)
Physician	Fee schedule (RBRVS)
Durable Medical Equipment	DMEPOS Fee schedule
Clinical Laboratory	Clinical Lab Fee schedule
Home Health	Episodes of care (case mix adjusted)
Covered drugs/biologicals	Mostly Average Sales Price (ASP)

Physician Fee Schedule

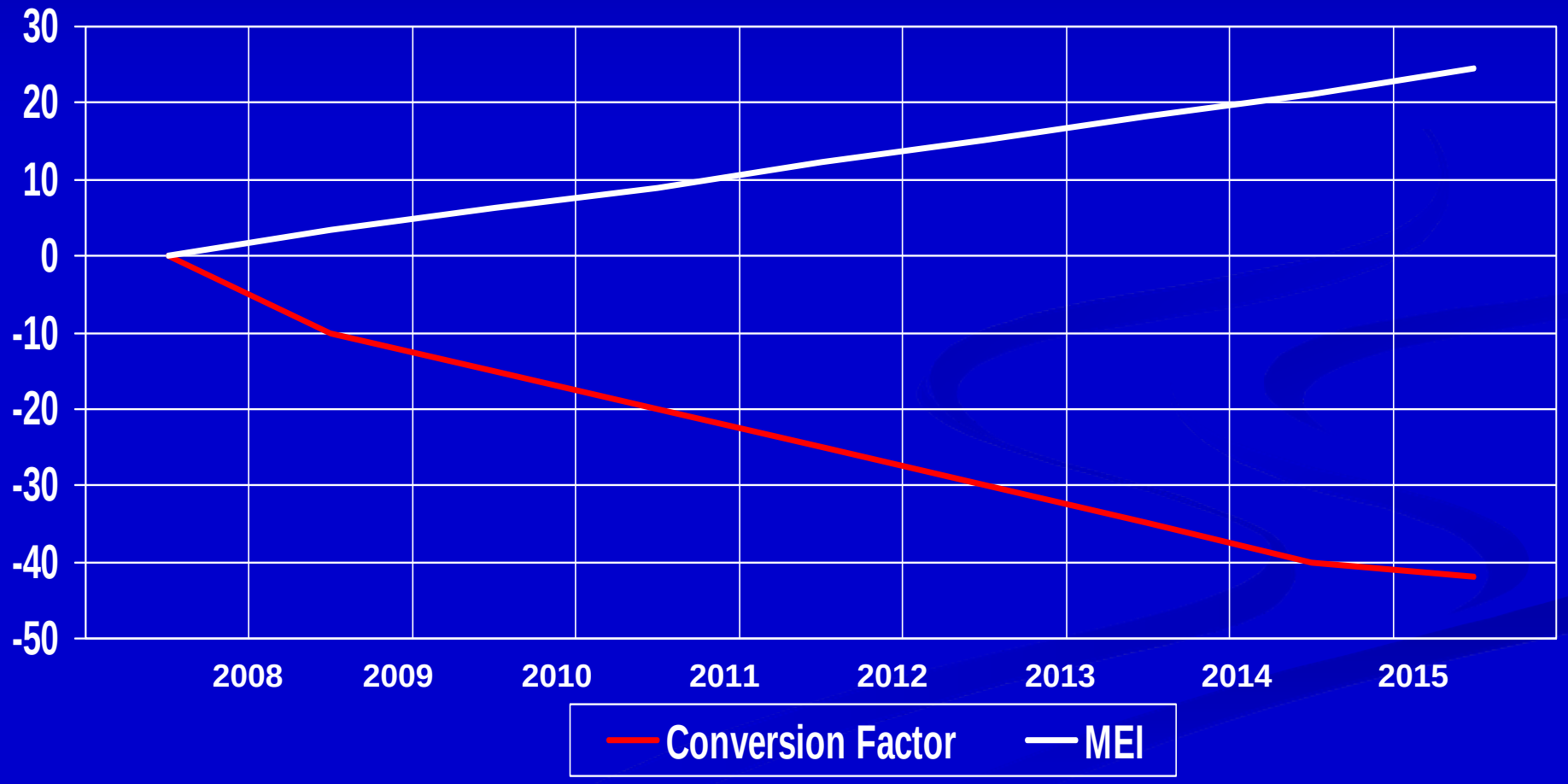
- Implemented 1993
- Payments calculated based on the relative costs of resources required to provide medical services
- Three components
  - Physician Work -- about 53%
    - $40 billion
  - Practice Expense -- about 43%
    - $32 billion
  - Malpractice -- about 4%
    - $3 billion
- Each component is assigned a relative value unit (RVU)
- Summed RVUs are multiplied by a dollar conversion factor to calculate payment
  - Payments adjusted for geographical location
- Most surgical services are paid on a global basis

Medicare Physician Payments: Facing a Cliff

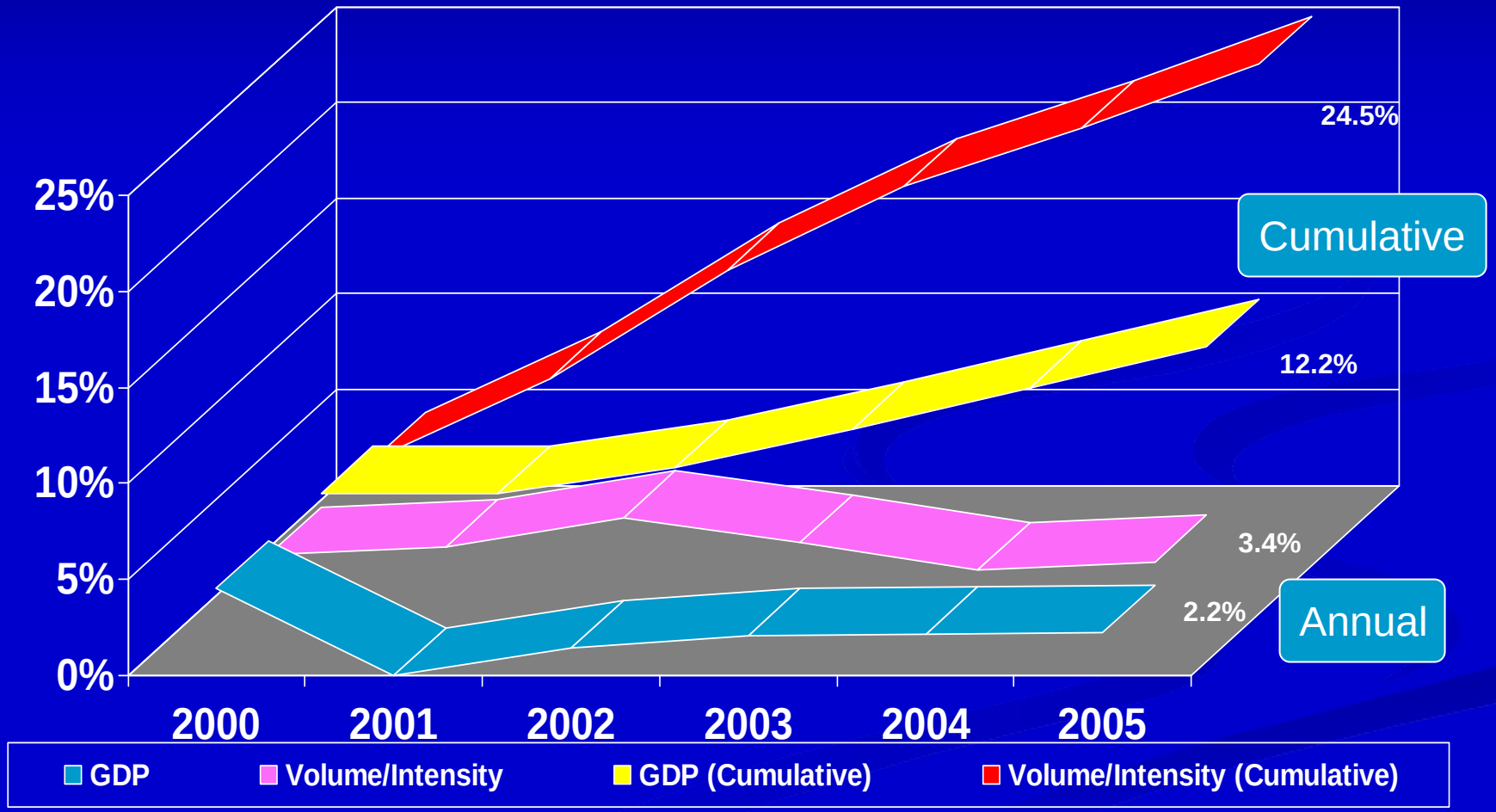
- May 1, 2006 Trustees Report projects physician updates of about -5 percent for at least 9 consecutive years, from 2007 through 2015
- By 2015, payment rates will fall by more than 35 percent compared to 2001
  - cost of providing care, as measured by the MEI, is projected to increase 40 percent over the period 2001-2015
- Negative updates will continue after 2015, which is beyond current trustees report projection
- Negative updates are driven by the SGR – "Sustainable Growth Rate" – which limits volume and intensity growth to growth in real GDP

MedPAC SGR Report

Future Cuts: 2008-2015



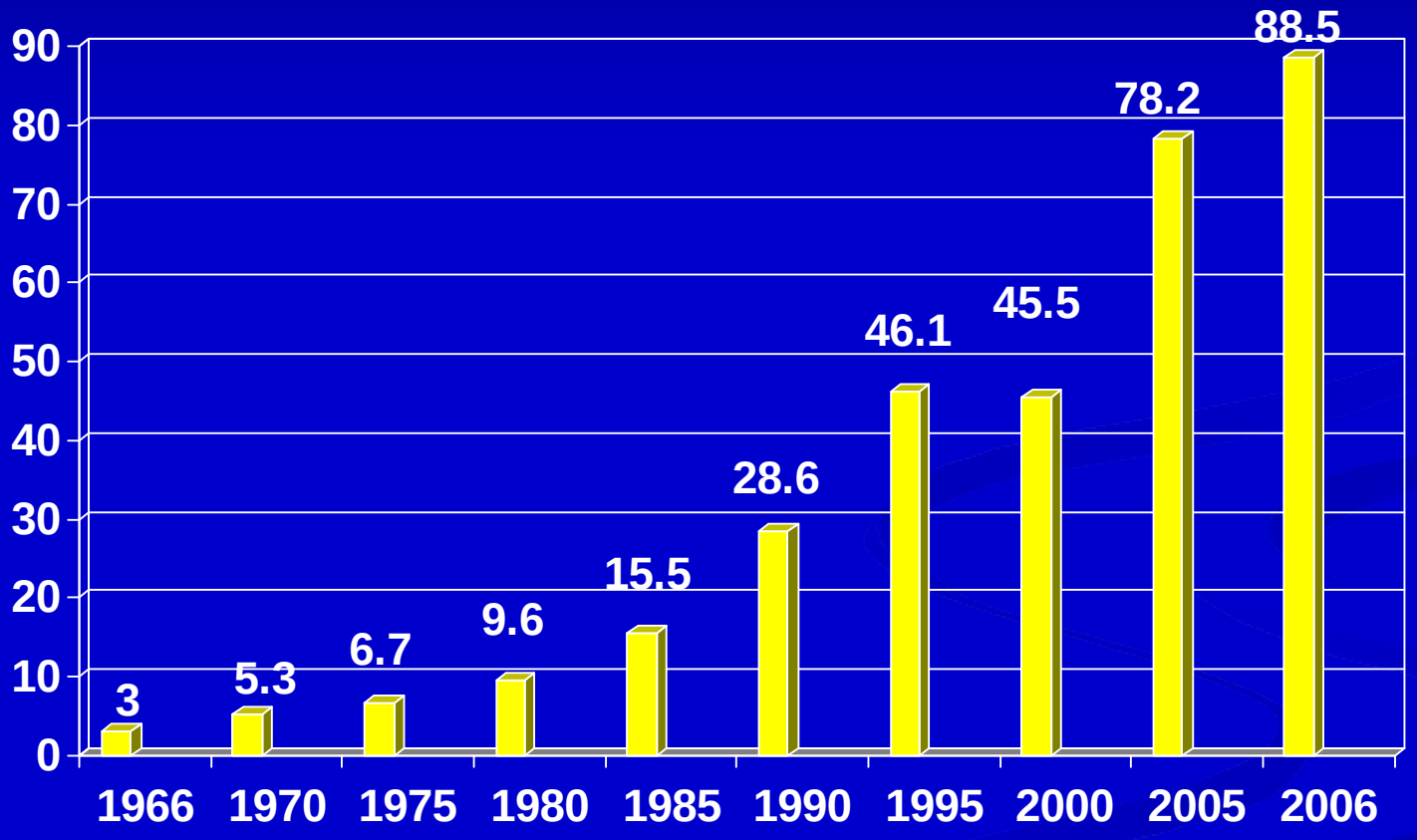
SGR Structural Problem: Volume and Intensity Growth Exceeds GDP



Fixing the Physician Update Problem

- Even a 10-year rate freeze is expensive
  - $180 billion in Federal dollars that would increase the Federal deficit by the same amount
  - $50 billion in increased beneficiary premiums
- CMS has not made administrative changes that could reduce budget score for legislation

Medicare Monthly Part B Premiums Are Rising Significantly



Part B premium increased from $50 in 2001 to $93.50 in 2007; 2007 increase will be lowest since 2001

Hospital Outpatient Prospective Payment System (OPPS)

- Ambulatory Patient Classification (APC)
- An APC is roughly equivalent to a procedure; a clinic or ER visit; or an item, such as a drug or device
  - Identified by a CPT or HCPCS code
- Generally, a separate payment is made for each item or service provided during an outpatient visit
  - Payments based on relative median costs of services in an APC compared to all APCs
  - Rates include certain packaged items (anesthesia, supplies, certain drugs, and the use of recovery/observation rooms)

OPPS Impact on Hospitals, 2003-2006

	2003	2004	2005	2006	Cumulative	
Market Basket	3.50%	3.40%	3.30%	3.70%	14.64%	
All Hospitals	3.70%	4.50%	4.00%	2.30%	15.29%	
Urban Hospitals	3.10%	4.30%	3.90%	2.00%	13.96%	
Large Urban	3.10%	4.20%	3.90%	1.20%	12.96%	
Other Urban	3.10%	4.40%	3.90%	2.80%	14.97%	
Rural	6.20%	4.90%	4.50%	3.90%	20.96%	
Major Teaching	2.70%	3.70%	2.60%	1.00%	10.36%	
Cancer	0.40%	3.20%	0.70%		4.34%	6.4%

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Source: CMS Regulation Impact Tables

Inpatient Hospital PPS

- All-inclusive, fixed payment per admission determined by DRG (Diagnosis Related Group)
- Bundled hospital payment – covers all services over hospital stay except physician/practitioner services
- Guiding Philosophy: hospitals should make both clinical and economic decisions
- What is a DRG?
  - Patient classification system used to categorize different types of inpatients
  - DRGs set out patient classes based on severity of illness that take into account resource demands and costs experienced by the hospital
  - Relative payment weights are calculated for a DRG based on its average costs relative to average costs for all DRGs

Inpatient Hospital PPS

- Assignment to DRG based on
  - Specific principal diagnosis: the cause for admission as determined after treatment and discharge
  - Age of patient
  - Presence of major surgical procedure (surgical DRGs) or absence thereof (medical DRGs)
  - Complications and co-morbidities
- DRG weights are re-calibrated annually
  - Adjust to new technology with two-year lag
  - Special add-on payments sooner for qualifying new technologies

Current Fee-for-Service Payment Issues

- Hospital inpatient PPS
  - FY 2008 Inpatient Hospital Regulation put on public display on April 13; will be published May 3; comment period closes June 12
  - Payment accuracy and specialty hospital issue still driving PPS reform
  - MedPAC: Indirect teaching and disproportionate share payments
    - Are the current levels of the IME and DSH adjustments justified?
      - MedPAC says any savings should be returned to the base rates
  - Outlier payments
    - With severity adjusted DRGs, should outlier policy be changed?
- Quality, pay-for-reporting, value-based purchasing
  - Hospitals: pay-for-reporting continues; value-based purchasing could start in FY 2009 (legislation needed)
  - Physician Quality Reporting Initiative (PQRI); pay-for-reporting for July-December 2007