Roadmap

• Introduction to Medicare Payment Systems
• Inpatient Prospective Payment System
• Physician Fee Schedule
• Post-Acute Care Services
• Q & A
Total benefit spending for CY2007 = $428 billion

Source: CMS Office of the Actuary, 2008
Medicare spending in selected settings

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of providers</th>
<th>2007 Medicare program spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital inpatient (general acute)</td>
<td>PPS: 3,400, CAH: 1,300</td>
<td>$107 billion</td>
</tr>
<tr>
<td>Hospital outpatient (general acute)</td>
<td>PPS: 3,400</td>
<td>$29 billion</td>
</tr>
<tr>
<td>Physicians &amp; LLPs*</td>
<td>785,000</td>
<td>$60 billion</td>
</tr>
<tr>
<td>Home health</td>
<td>9,400</td>
<td>$15.8 billion</td>
</tr>
<tr>
<td>SNF</td>
<td>15,000</td>
<td>$22.1 billion</td>
</tr>
</tbody>
</table>

* Limited licensed practitioners
Components of Medicare spending

\[
\text{Number of beneficiaries} \times \text{Number of Services} \times \text{Payments per service} = \text{Total program expenditures}
\]

(population) (utilization) (payment rates)
Principles of Medicare Payment

- Ensure beneficiary access to high quality care in an appropriate setting
- Give providers an incentive to supply care efficiently
- Pay similarly for services, irrespective of setting
- Control program spending
Structural elements of a PPS

- What is a prospective payment system?
- Defining the products and services
  - Unit of payment
  - Classification system
- Setting relative values
- Setting a national base payment rate
Structural elements of a PPS, continued

- Adjusting for local market conditions
  - Variation in the cost of providing care (input prices)
- Other adjustments (teaching; nonphysicians)
- Updating payment rates
## Key elements of selected payment systems

<table>
<thead>
<tr>
<th>Payment system description</th>
<th>Inpatient acute care hospitals</th>
<th>Home health agencies</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product definition</strong></td>
<td><strong>Unit of payment</strong></td>
<td><strong>Classification system</strong></td>
<td>hospital stay</td>
</tr>
<tr>
<td></td>
<td><strong>Unit of payment</strong></td>
<td><strong>Classification system</strong></td>
<td>745 MS-DRGs</td>
</tr>
<tr>
<td></td>
<td><strong>Relative values</strong></td>
<td><strong>Components of relative values</strong></td>
<td>Single value for each DRG</td>
</tr>
<tr>
<td></td>
<td>Sources of relative values</td>
<td><strong>Components of relative values</strong></td>
<td>Hospitals’ billed costs</td>
</tr>
</tbody>
</table>

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**MEDPAC**
Key elements of selected payment systems, continued

<table>
<thead>
<tr>
<th>Payment system description</th>
<th>Inpatient acute care hospitals</th>
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</thead>
<tbody>
<tr>
<td><strong>Base rate</strong></td>
<td>Updated providers’ 1982 costs</td>
<td>Spending in preceding system</td>
<td>Projected spending under preceding payment method</td>
</tr>
<tr>
<td>Source of base amount</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Local market adjustments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Labor input prices</strong></td>
<td>Hospital wage index (HWIr)</td>
<td>Hospital wage index (HWIu)</td>
<td>Separate GPCIs: work, practice expenses, PLI</td>
</tr>
</tbody>
</table>
### Key elements of selected payment systems, continued

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<thead>
<tr>
<th>Payment system description</th>
<th>Inpatient acute care hospitals</th>
<th>Home health agencies</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other payment adjustments</td>
<td>Low-income patients (DSH); IME programs; rural payments</td>
<td></td>
<td>Shortage areas; Nonphysician practitioners (reduced rate)</td>
</tr>
<tr>
<td>Payments for capital costs</td>
<td>Separate prospective rates</td>
<td>Included in payment rate</td>
<td>Included in payment for practice expense</td>
</tr>
</tbody>
</table>
Total spending for 2007=$428 billion

Outpatient prescription drugs 12%
Managed care 18%
Other fee-for-service settings 12%
Home health 4%
Skilled nursing facility 5%
Hospital inpatient 29%
Hospital outpatient 6%
Physician 14%

Source: CMS Office of the Actuary, 2008, as reported by MedPAC
Other Part A & B Payment Systems

- Hospital Outpatient Prospective Payment System (OPPS)
- Post-Acute Care (PAC)
- Ambulatory surgical centers (ASCs)
- End-Stage Renal Disease (ESRD)
- Clinical laboratory services
- Ambulance services
- Durable medical equipment (DME)
- Part B drugs

- **Not** included in a prospective payment system or fee schedule
  - Cancer hospitals, children’s hospitals, critical access hospitals
Other Medicare Payment Systems

- Medicare Advantage plans (Part C)
- Prescription drug plans (Part D)
Inpatient Prospective Payment System (IPPS)

• IPPS replaced the previous cost-based reimbursement system in FY 1984

• Under IPPS, hospitals generally receive a fixed predetermined amount for each inpatient hospital stay, regardless of their actual costs

• The payment amount is based largely on the patient’s principal diagnosis

• First prospective payment system used in Medicare
Two Major Changes in IPPS Will Be Completed in 2009

- Charge-based \rightarrow\text{Cost-based Diagnosis-Related Groups (DRG) weights}
- DRGs \rightarrow\text{Medicare Severity Diagnosis-Related Groups (MS-DRGGS)}
What are MS-DRGs?

- MS-DRGs identify patients with similar clinical problems who are expected to consume similar amounts of hospital resources.
- Groupings are based on factors such as patient diagnoses and whether the patient had surgery.
- There are about 300 base DRGs that are split into more than 700 MS-DRGs depending on the presence of a (major) comorbidity or complication.
- Each MS-DRG is assigned a relative weight, which compares its costliness to the average Medicare case.
IPPS Payment: Two Payment Components

Operating Payment + Capital Payment

• Payment per discharge
• Hospital-specific formula
# IPPS: Operating Payment Formula

\[
\text{Payment} = \text{Base rate} \times \text{Wage index} \times \text{MS-DRG weight} + \text{Add-on payments}
\]

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base rate</strong></td>
<td>Standardized payment amount divided into labor/non-labor components (separate payment for capital costs)</td>
</tr>
<tr>
<td><strong>Wage index</strong></td>
<td>Accounts for geographic variation in hospitals’ labor costs (applied only to labor portion of the base rate)</td>
</tr>
<tr>
<td><strong>MS-DRG weight</strong></td>
<td>Reflects a patient’s relative costliness</td>
</tr>
<tr>
<td><strong>Add-ons</strong></td>
<td>Includes teaching hospitals/ indirect graduate medical education (IME), hospitals treating a disproportionate share of low-income patients (DSH), costly cases</td>
</tr>
</tbody>
</table>

Note: The formula shown is a simplified version of the payment formula.
Inpatient PPS: Payment Example

MS-DRG 231- Coronary bypass w/ percutaneous transluminal coronary angioplasty (PTCA) and major complication or comorbidity

- Major diagnostic category 5: Circulatory diseases
- Surgical MS-DRG
- Performed at a local Washington DC hospital that has a teaching program and treats a large share of low-income patients

\[
\text{[ (Base rate labor x Wage index) + (Base rate non-labor) ] x MS-DRG weight}
\]

\[
[((3,574.50 \times 1.0974) + 1,553.91) \times 7.6438 = 41,861.78
\]

Add-ons
- IME = $13,917.79
- DSH = $6,532.53

\[
$62,312.10
\]

Note: This payment is for operating costs only, based on rates for FY2009.
IPPS Issues
Payments for Physician Services

- The physician fee schedule (PFS) replaced the previous reasonable charge method in 1992
- Services include office visits, surgical procedures and diagnostic tests, and are identified by over 7,000 procedure codes
- The fee schedule is based on resource-based relative value scale (RBRVS)
- Spending targets are set by the Sustainable Growth Rate (SGR) system to update physician fees annually
Nationally Uniform Relative Value Units

• Under the RBRVS, each physician service is given a weight that measures its relative costliness
• The weights, known as relative value units (RVUs), have 3 components:

<table>
<thead>
<tr>
<th>RVU</th>
<th>Physician work</th>
<th>Practice expense</th>
<th>Malpractice expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time, skill, &amp; training</td>
<td>Rent, utilities, equipment, supplies, staff</td>
<td>Liability coverage</td>
</tr>
</tbody>
</table>
# Physician Payment Formula

$$\text{Payment} = \text{RVU} \times \text{Geographic adjustment} \times \text{Conversion factor}$$

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>RVU</td>
<td>Reflects relative cost of physician service</td>
</tr>
<tr>
<td>Geographic adjustment</td>
<td>Accounts for geographic variation in the cost of providing physician services</td>
</tr>
<tr>
<td>Conversion factor</td>
<td>Converts adjusted RVU into dollar amounts</td>
</tr>
<tr>
<td>*Other adjustments</td>
<td>e.g., Non-physician providers, Health Professional Shortage Areas</td>
</tr>
</tbody>
</table>

Note: The formula shown is a simplified version of the payment formula.
Physician Payment: Example 1

Office visit, detailed (established patient)
- Procedure code 99213
- Performed by Washington DC physician in a non-facility setting

\[
\text{RVU} \times \text{Geographic adjustment} \times \text{Conversion factor} \\
1.70 \times 1.121 \times \$36.0666 \\
= \$68.73
\]

Note: This example is based on current rates effective January 1, 2009.
Physician Payment:  
Example 2

Knee arthroscopy/surgery
• Procedure code 29850
• Performed by Washington DC physician in a facility setting

\[ \text{RVU} \times \text{Geographic adjustment} \times \text{Conversion factor} \]
\[ 14.67 \times 1.121 \times $36.0666 \]
\[ = $593.12 \]

Note: This example is based on current rates effective January 1, 2009.
Sustainable Growth Rate (SGR) is the system used by Medicare to annually update physician fees

- The SGR system sets spending targets and adjusts physician fees based on the extent to which actual spending aligns with specified targets.

- The SGR system has called for fee reductions largely in response to increased spending caused by Medicare beneficiaries receiving an increasing volume and intensity of services.

- Under current law, the fees that Medicare pays to physicians will be reduced by 21 percent in 2010. Past fee reductions have been averted by administrative and legislative actions since 2002.
Growth in Volume and Intensity of Medicare Physician Services per FFS Beneficiary, 1980-2007

Percentage

Fee schedule and spending targets first affected updates

Charge-based system  Fee schedule and MVPSa  Fee schedule and SGR

*Medicare Volume Performance Standard

Source: GAO analysis of data from CMS and the Boards of Trustees of the Federal Hospital Insurance (HI) and Federal Supplementary Medical Insurance (SMI) Trust Funds.
PFS Issues
## Post-Acute Care and Related Services

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<tr>
<th>Type</th>
<th>Number of providers</th>
<th>2007 Medicare program spending</th>
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<td>Skilled Nursing Facility (SNF)</td>
<td>15,000</td>
<td>$22.1 billion</td>
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<tr>
<td>Home health</td>
<td>9,400</td>
<td>$15.8 billion</td>
</tr>
<tr>
<td>Inpatient Rehab Facility (IRF)</td>
<td>1200</td>
<td>$6 billion</td>
</tr>
<tr>
<td>Long-term Care Hospital (LTCH)</td>
<td>400</td>
<td>$4.5 billion</td>
</tr>
<tr>
<td>Hospice</td>
<td>3250</td>
<td>$10.1 billion</td>
</tr>
</tbody>
</table>
Issues in Post-Acute Care

- PPS’ vary (daily/discharge/episode)
- Patient selection
- No common patient assessment tools
- More difficult to define services and episode (e.g. home health)
- Medicare pays differently across settings for the “same” patient