

Medicare Payment System Design: An Overview

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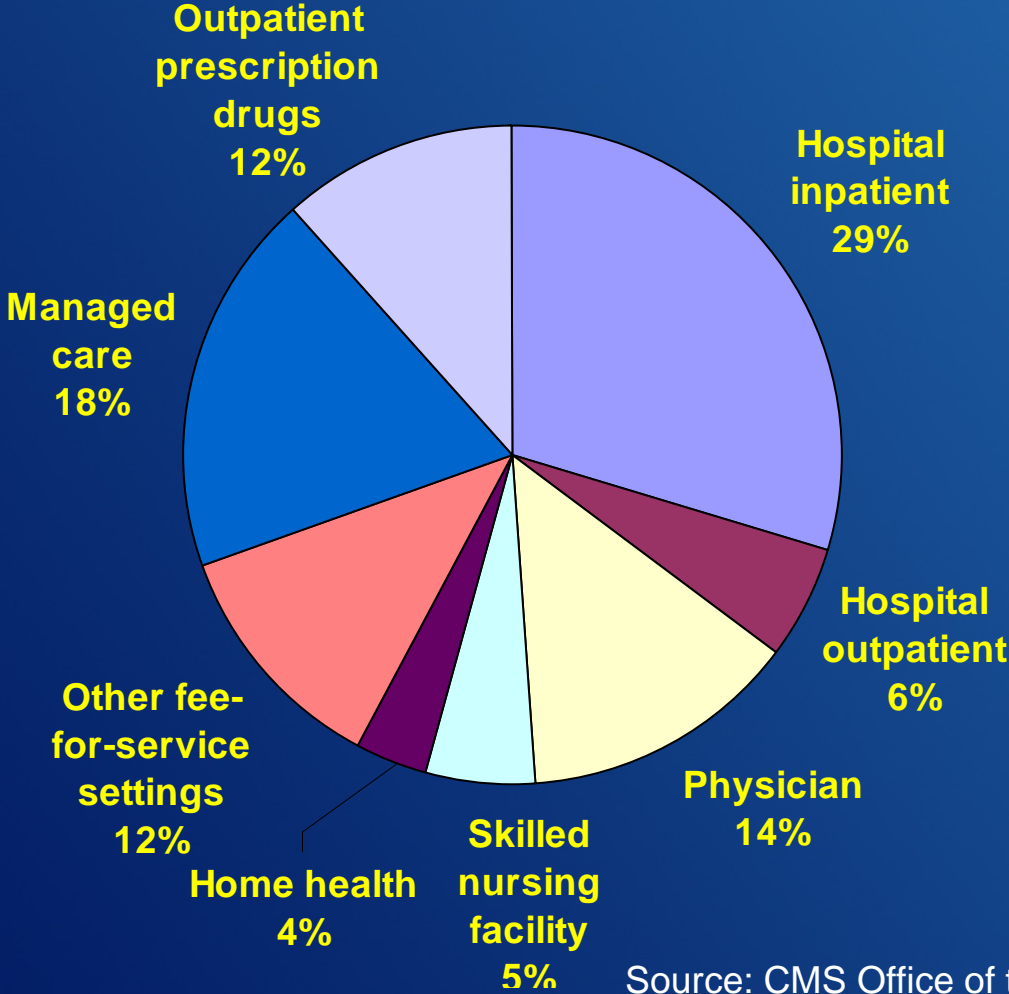
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Roadmap

- 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

Type	Number of providers	2007 Medicare program spending
Hospital inpatient (general acute)	PPS: 3,400 CAH: 1,300	\$107 billion
Hospital outpatient (general acute)	PPS: 3,400	\$29 billion
Physicians & LLPs*	785,000	\$60 billion
Home health	9,400	\$15.8 billion
SNF	15,000	\$22.1 billion

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

Payment system description	Inpatient acute care hospitals	Home health agencies	Physicians
Product definition			
Unit of payment	Hospital stay	60-day episode	Service
Classification system	745 MS-DRGs	153 HHRGs	6,700+ HCPCS codes
Relative values			
Components of relative values	Single value for each DRG	Single value for each HHRG	Physician work; practice expense; liability insurance
Sources of relative values	Hospitals' billed costs	Estimated mean cost per HHRG	Expert judgment; practice expense data; premium survey

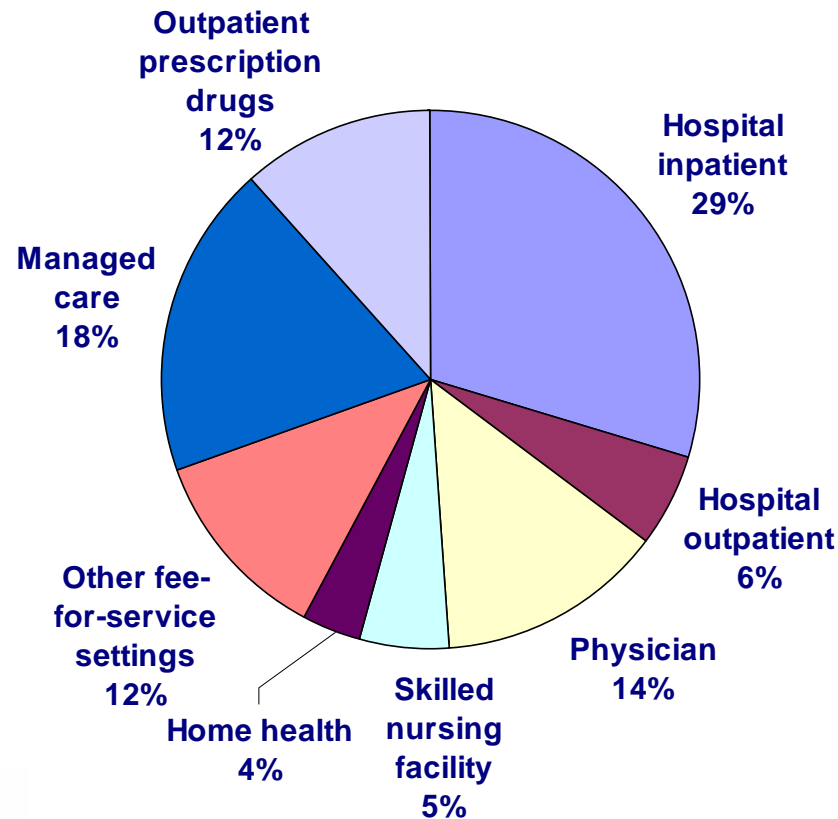
Key elements of selected payment systems, continued

Payment system description	Inpatient acute care hospitals	Home health agencies	Physicians
Base rate Source of base amount	Updated providers' 1982 costs	Spending in preceding system	Projected spending under preceding payment method
Local market adjustments Labor input prices	Hospital wage index (HWI _r)	Hospital wage index (HWI _u)	Separate GPCIs: work, practice expenses, PLI

Key elements of selected payment systems, continued

Payment system description	Inpatient acute care hospitals	Home health agencies	Physicians
Other payment adjustments	Low-income patients (DSH); IME programs; rural payments		Shortage areas; Nonphysician practitioners (reduced rate)
Payments for capital costs	Separate prospective rates	Included in payment rate	Included in payment for practice expense

Total spending for 2007=\$428 billion



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
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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
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Two Major Changes in IPPS Will Be Completed in 2009

- Charge-based → Cost-based Diagnosis-Related Groups (DRG) weights
- DRGs → Medicare Severity Diagnosis-Related Groups (MS-DRGs)

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
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IPPS Payment: Two Payment Components

Operating Payment + Capital Payment

- Payment per discharge
- Hospital-specific formula

IPPS: Operating Payment Formula

**Payment = Base rate x Wage index x MS-DRG weight
+ Add-on payments**

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

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

[(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.

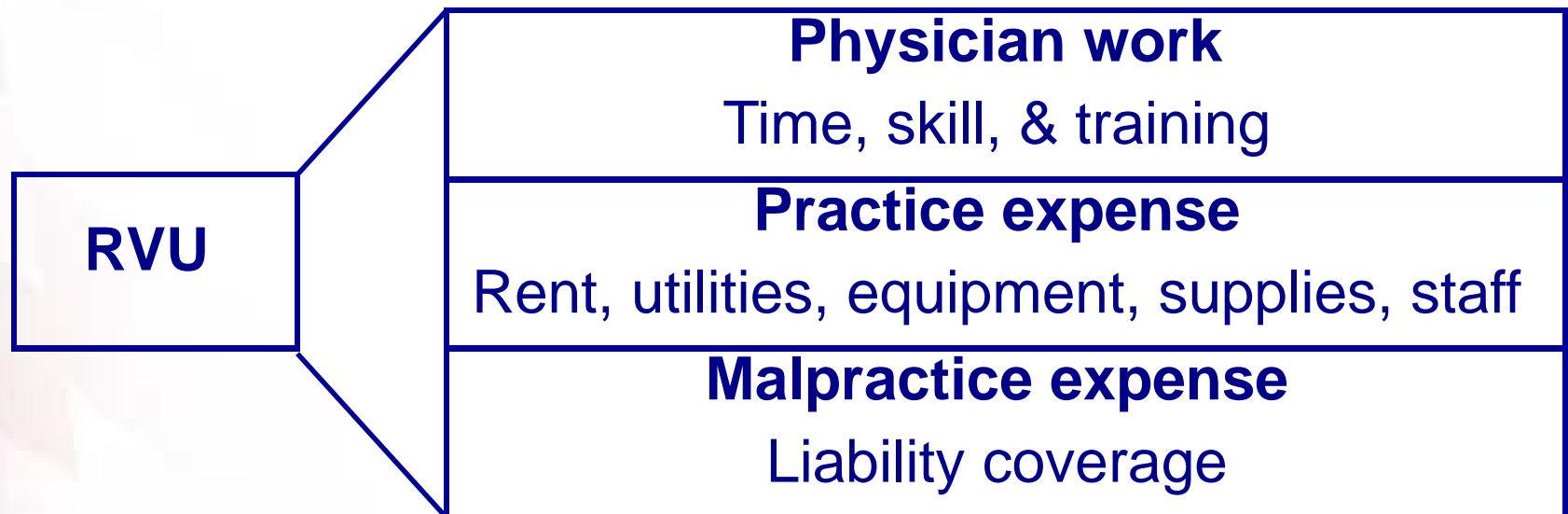
IPPS Issues

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:



Physician Payment Formula

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

RVU	Reflects relative cost of physician service
Geographic adjustment	Accounts for geographic variation in the cost of providing physician services
Conversion factor	Converts adjusted RVU into dollar amounts
*Other adjustments	e.g., Non-physician providers, Health Professional Shortage Areas

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

RVU x Geographic adjustment x Conversion factor

1.70 x 1.121 x \$36.0666

= **\$68.73**

Physician Payment: Example 2

Knee arthroscopy/surgery

- Procedure code 29850
- Performed by Washington DC physician in a facility setting

RVU x Geographic adjustment x Conversion factor

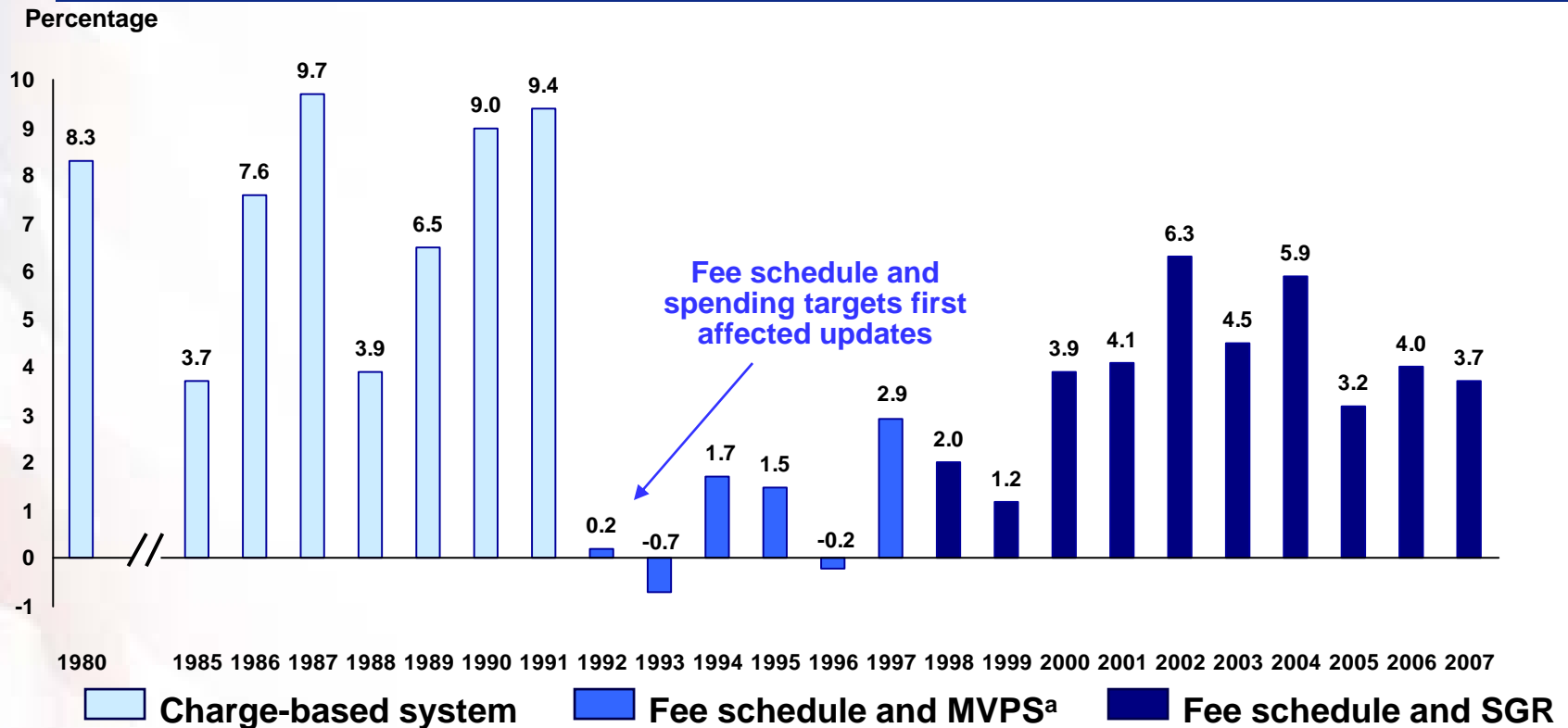
14.67 x 1.121 x \$36.0666

= **\$593.12**

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.
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Growth in Volume and Intensity of Medicare Physician Services per FFS Beneficiary, 1980-2007



^aMedicare 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

Type	Number of providers	2007 Medicare program spending
Skilled Nursing Facility (SNF)	15,000	\$22.1 billion
Home health	9,400	\$15.8 billion
Inpatient Rehab Facility (IRF)	1200	\$6 billion
Long-term Care Hospital (LTCH)	400	\$4.5 billion
Hospice	3250	\$10.1 billion

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