# Introduction to the Centers for Medicare & Medicaid Services (CMS) Payment Process

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# Overview

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- Paths to Medicare Coverage
- Key questions: What does Medicare cover?  How much does Medicare pay?
- Medicare Part A and Part B:
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  - Payment Systems
  - CMS Rulemaking Process
- CMS Regulatory Clearance Process
- Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Benefit)
- Concluding Thoughts

# Medicare Basics

- Federal health insurance program established in 1965.
- Currently covers 45 million Americans.
- In 2009, comprised an estimated 13% of the federal budget, and 19% of national health expenditures.
- Medicare is divided into four main parts:
  - **Part A** (Institutional services)
  - **Part B** (Outpatient services) - physician, outpatient, home health, and preventive services
  - **Part C** (Medicare Advantage program) - private plans receive payments from Medicare for Medicare-covered and supplemental benefits, and
  - **Part D** (Outpatient Prescription Drug Benefit) - private plans contract with Medicare, either stand alone prescription drug plans, or MA prescription drug plans

# Paths to Medicare Coverage

- Three primary categories of Medicare beneficiaries, those who qualify by (1) age, (2) disability, and (3) end-stage renal disease:
  - Age: Individuals 65 years of age and over and who are eligible (or their spouse is eligible) for Social Security payments.
    - Usually automatically enrolled in Medicare Part A (Hospital Insurance Program).
  - Disability: Individuals under 65 years of age and who receive Social Security cash payments due to a disability.
    - Can generally become eligible for Medicare after a two-year waiting period.
  - End-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS): Individuals who have ESRD or ALS (Lou Gehrig's disease).
    - Automatically qualified for Medicare regardless of age.
- Medicare Part B is voluntary, but covers 95% of all Part A beneficiaries.
- Individuals are eligible for Medicare Advantage if they are entitled to Part A and enrolled in Part B.
- Individuals are eligible for prescription drug coverage under a Part D plan if they are entitled to benefits under Part A or enrolled in Part B.

# Two Key Medicare Questions

- (1) Is the item or service covered by Medicare?
  - Medicare coverage and payment rules are based on whether a product or service fits into a covered benefit category.
  - Most categories defined in §§ 1812, 1832 and 1861(s).
- (2) If so, how is it paid for?
  - Medicare Part A and Part B- six payment systems (described in following slides)
  - Medicare Advantage, competitive bidding
  - Part D Prescription Drug Coverage, competitive bidding

# CMS Coverage Process

- Medicare Part A and Part B cover the following:
  - Part A Covered Benefits
    - Inpatient care provided to beneficiaries in hospitals and short-term stays in skilled nursing facilities
    - Hospice care
    - Post-acute home health care
  - Part B Covered Benefits
    - Outpatient services, such as outpatient hospital care, physician visits, and other medical services, including preventive services.
    - Ambulance services
    - Clinical laboratory services
    - Durable medical equipment
    - Kidney supplies and services
    - Outpatient mental health care

# CMS Coverage Process (Cont'd)

- In order for Medicare to cover and pay for an item or service, it must be medically necessary.

  – "Reasonable and necessary" requirement: the Social Security Act provides that Medicare may not pay for expenses of items and services that are not "reasonable and necessary" for the diagnosis or treatment of illness and injury. § 1862(a)(1)(A).

# CMS Coverage Process (Cont'd)

- National Coverage Determination and Local Coverage Determinations

  – National Coverage Determinations (NCD)

    - NCDs establish a substantive legal standard for Medicare coverage CMS typically makes only 20-30 NCDs per year.
    - When adopted by CMS, the NCD specifies whether CMS will or will not cover specific items and the circumstances under which they may be covered.

  – Local Coverage Determinations (LCD)

    - Most coverage decisions are made through LCDs at the local level by Medicare contractors.
    - The Medicare Program Integrity Manual (PIM) lays out criteria including that items or services receiving LCDs must be safe and effective; not experimental or investigational.

# Medicare Payment Systems

- Medicare pays for covered products and services furnished to Medicare beneficiaries based on six major payment system groups:
  - (1) inpatient acute care;
  - (2) ambulatory care furnished by physicians, hospital outpatient departments, ASC, and clinical labs;
  - (3) post-acute care furnished by SNF, home health agencies, inpatient rehabilitation facilities and long-term care hospitals;
  - (4) dialysis services;
  - (5) ambulance services and products furnished by DME suppliers; and
  - (6) services furnished by private health plans under the Medicare Advantage program.

# Inpatient and Outpatient PPS Payment

- Inpatient Prospective Payment System (IPPS)
  - Payment system for operating costs of acute care hospital inpatient stays under Part A
  - Each case categorized into a diagnosis-related group (DRG), which has a payment weight assigned to it based on the average resources used to treat Medicare patients in that DRG
  - IPPS base payment amount is adjusted by DRGs and other factors (labor costs, teaching, disproportionate share)

- Outpatient Prospective Payment System (OPPS)
  - Payment system for hospital outpatient services, certain Part B services furnished to hospital inpatients who have no Part A coverage and partial hospitalization services furnished by community mental health centers.
  - All services classified into groups called Ambulatory Payment Classifications (APCs).
  - APCs contain services which are similar clinically and in terms of resources required.
  - OPPS base payment amount gets adjusted by APC

# Physician Fee Schedule (PFS) Payment

- Medicare's PFS provides policies and prospective maximum payment rates for services furnished by physicians and nonphysician practitioners

- PFS lists more than 7,000 covered services, including:
  - office visits, surgical procedures, and diagnostic and therapeutic services, which can be furnished in many settings such as the physician's office, hospital, beneficiary's home.

- PFS is based on a base payment rate, adjusted by:
  - relative value units (RVUs) based on resources required, annual physician conversion factor, and geographic practice cost indices, to adjust for variances in geographic markets.

- Sustainable Growth Rate (SGR) is the formula used annually to adjust the PFS base rate.
  - SGR has resulted in negative updates every year starting in CY 2002. Congressional legislative action prevented the reductions in CY 2004 – CY 2009.
  - CY 2010 projected rate reduction is -21.5%, based on current data.

# Post-Acute Care, Durable Medical Equipment, Ambulance Services Payment

- Post-Acute Care –
  - Most post-acute providers (e.g., SNFs, LTACHs) paid under a prospective payment model
  - Post Acute Care (PAC) Payment Reform Demonstration in place since 2008 with the goal of standardizing patient assessment information from PAC settings; report to be submitted to Secretary 2011.

- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) –
  - The Medicare Modernization Act of 2003 (MMA) requires DMEPOS to utilize a competitive bid payment system rather than the former DMEPOS fee schedule payment amounts for selected items in selected areas.
  - Competitive bid payment amounts determined by using bids submitted by DMEPOS suppliers.

- Ambulance services-
  - National fee schedule covers specifically for ambulance services furnished as a benefit under Medicare Part B, as required by the Balanced Budget Act (BBA) of 1997.
  - Ambulance providers and suppliers must accept the Medicare allowed charge as payment in full and not bill or collect from the beneficiary any amount other than any unmet Part B deductible and Part B coinsurance amounts.

# End-Stage Renal Disease (ESRD) Payment

- Current ESRD payment system:
  - Medicare pays ESRD facilities a composite rate; separately payable drugs not in the composite rate, including injectable drugs such as erythropoietin (EPO); and non-routine laboratory tests
    - Composite Rate covers dialysis treatment costs and certain routinely furnished ESRD-related drugs, laboratory tests, and supplies, and is adjusted by a drug add-on payment that accounts for changes in the drug pricing methodology, by case mix adjustment factors, and geographic differences

- ESRD moving to a new payment system, effective Jan. 1, 2011, as required by statute (MIPPA of 2008).
  - New system to trim 2% of the estimated payments that would have been made in 2011 under the previous section.

- New ESRD System will be to bundle everything into one payment.
  - CMS proposal: to pay a base rate of $198 per dialysis treatment.
    - Base rate represents the average Medicare allowable payment per treatment for composite rate and separately billable services, including training and home dialysis costs, laboratory services and all ESRD-related Part B and former Part D drugs.
  - Proposed base rate to be adjusted to reflect patient- and facility-specific differences in case mix

# The Role of MedPAC in the Process

- What is MedPAC?
  - The Medicare Payment Advisory Commission
  - An independent, Congressionally-established 17-member body that makes recommendations to Congress and the Administration on Medicare payment policy
  - MedPAC meets seven times per year
  - MedPAC recommendations are advisory only; Congress or CMS are not required to act on their recommendations, but their recommendations are afforded great weight as the entity is immune from political considerations.
- Potential future role of MedPAC
  - The Obama Administration has recommended giving MedPAC dramatically enhanced power.
  - Under the recommendations, MedPAC recommendations would go to the President who could approve them or disapprove them in their entirety
    - If the President approved, Congress would have to pass a resolution of disapproval, which would be subject to a Presidential veto.
    - The effect would be an enormous shift of power from the Legislative Branch to the Executive Branch.
- Past recommendations of MedPAC
  - Reduce Medicare Advantage benchmarks so they are equivalent to FFS Medicare
  - Reductions in provider market basket updates
  - ESRD bundled payment system and inclusion of products in bundle

# CMS Rulemaking Process

- CMS publishes all payment rules in the Federal Register.

- Payment rules consist of:
  - Proposed Rule
  - Public Comment Period- for Medicare rules, comment period must be 60 days.
  - Final Rule

- Timeframe:
  - Part A (IPPS, SNF, non-acute hospitals) - Final Rule by Aug. 1
  - Part B (Physician Fee Schedule, OPPS, home health) - Final Rule by Nov. 1

- *Note*: Medicare Advantage and Part D: not determined by rulemaking but through requests for bids issued in January.

# CMS Rulemaking Process (Cont'd)

- In addition to publishing annual payment rules, CMS can publish rules that implement Congressional or Administration policy. These include:
  - Medicare Advantage and Part D policy changes
  - ESRD payment bundle
  - Emergency Medical Treatment and Labor Act (EMTALA)
  - Health Information Technology for Economic and Clinical Health Act (HITECH)
  - Children's Health Insurance Program Reauthorization Act (CHIPRA)

# CMS Regulatory Clearance Process

- CMS rules must go through the following steps:
  - Approval by CMS
  - Approval by the Department of Health and Human Services (HHS)
  - Approval by the Office of Management and Budget (OMB)
  - Approval by the White House
  - Publishing in the Federal Register.

# Medicare Advantage (MA)

- Market-based system where government guarantees a contribution, not a benefit package

- Medicare Advantage (MA) plans
  - Include HMO, PPO, Private fee-for-service plans, Medicare Special Needs Plans and Medicare Medical Savings Account Plans (MSA).

- MA Bidding system
  - Plans bid to offer Parts A and B coverage to beneficiaries; bid includes plan administrative cost and profit.
  - CMS bases its payment to the plan on the relationship between the plan's bid and benchmark (bidding target, updated yearly).

- Overpayments Issue
  - Studies have shown that MA plans will be paid $11.4 billion more in 2009 than would have been paid for the same beneficiaries in traditional Medicare fee-for-service.

# Medicare Part D – Prescription Drugs

- Like MA, market-based system where government guarantees a contribution, not a benefit package

- Medicare Part D Plans
  - Include stand-alone prescription drug plans and MA-Prescription Drug plans.
  - Plans compete for enrollees on the basis of annual premiums, benefit structures, specific drug therapies, pharmacy networks, and quality of services.

- Part D Bidding System
  - Plans submit bids annually to CMS reflecting plan's expected benefit payments plus administrative costs.

- Medicare Payment
  - CMS pays plans a monthly prospective payment for each enrollee. On average, Medicare provides a 74.5% subsidy of standard coverage for all types of beneficiaries.

# Concluding Thoughts

- Medicare a complicated, intricate program
  - Very much reflects a government-structured and guaranteed benefit design, with services provided by private parties and private administrative contractors.
  - Key to understanding Medicare is:
    - Coverage
    - Payment
- Politics drives many, but not all, of the decisions in Medicare
  - "Winners and losers" in payment policies
    - E.g., hospital wage index
  - CMS coverage process generally more immune to political influence
- Medicare is on an unsustainable financial path
  - Medicare currently is operating a cash deficit in Part A (i.e., fewer revenues coming in to part A trust fund than are being spent).
  - By 2016 or 2017, Part A will be insolvent.
- As such, it needs to move to a more financially stable model
  - Bundled payments
  - Pay for performance
  - Enhanced use of health IT