Medicare Payment Updates and Payment Rates

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Summary

Medicare is a federal insurance program that pays for covered health services for most persons 65 years of age and older and for most permanently disabled individuals under the age of 65. Part A of the program, the Hospital Insurance program, covers hospital, post-hospital, and hospice services. Part B, the Supplementary Medical Insurance program, is optional and covers a broad range of complementary medical services including physician, laboratory, outpatient hospital services, and durable medical equipment. Part C provides private plan options for beneficiaries enrolled in both Parts A and B. Part D is an optional outpatient prescription drug program.

Medicare has established specific rules for payment of covered benefits. Some, such as physician services and most durable medical equipment, are based on fee schedules. A fee schedule is a list of Medicare payments for specific items and services, which are calculated according to statutorily specified formula and take into account the actual amount of care provided. Many services, including inpatient and outpatient hospital care, are paid under different prospective payment systems (PPSs). A prospective payment system is a method of paying hospitals or other providers amounts or rates of payment that are established in advance for a defined period and are generally based on an episode of care, regardless of the actual amount of care used. Other payments are based, in part, on a provider's bid (an estimate of the cost of providing a service) relative to a benchmark (the maximum amount Medicare will pay). Bids and benchmarks are used to determine payments in Medicare Parts C and D. Payments for some items of durable medical equipment in specified locations are also based on the bids of competing providers.

In general, the program provides for annual updates to these payment amounts. The program also has rules regarding the amount of cost sharing, if any, that beneficiaries can be billed in excess of Medicare's recognized payment levels. Unlike other services, Medicare's outpatient prescription drug benefit can be obtained only through private plans. Further, while all Part D plans must meet certain minimum requirements, they differ in terms of benefit design, formulary drugs, premiums, and cost-sharing amounts.

Medicare payment policies and potential changes to these policies are of continuing interest to Congress. The Medicare program has been a major focus of deficit reduction legislation since 1980. In each Congress since the 105th Congress, laws have been passed to both increase, but more often slow, the rate of growth of payments to Medicare providers and private plans. Perhaps of particular interest in the 112th Congress is the update to the Medicare physician fee schedule. The method for updating the physician fee schedule amount, known as the sustainable growth rate (SGR), would have resulted in negative updates for physician payments in recent years, except that Congress has stepped in to stop the updates. Physician payment rates are frozen through December 31, 2012, after which point, rates will decrease by approximately 27% in the absence of further congressional action.

This report provides an overview of Medicare payment rules by type of service, outlines current payment policies, and summarizes the basic rules for payment updates. This report will be updated twice a year to reflect recent fiscal year and calendar year changes.

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Introduction

Medicare is a federal insurance program that pays for covered health services for most persons 65 years of age and older and for most permanently disabled individuals under the age of 65. Part A of the program, the Hospital Insurance program, covers hospital services, up to 100 days of post-hospital skilled nursing facility services, post-institutional home health visits, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of medical services including physician services,[1] laboratory services, durable medical equipment, and outpatient hospital services. Part B also covers some home health visits. Part C (also known as Medicare Advantage, or MA) provides private plan options, such as managed care, for beneficiaries who are enrolled in both Parts A and B. Part D provides optional outpatient prescription drug coverage.

Medicare Payment Principles

In general, the total payment received by a provider for covered services provided to a Medicare beneficiary is composed of two parts: a program payment from Medicare plus any beneficiary cost-sharing that is required.[2] (The required beneficiary out-of-pocket payment may be paid by other insurance, if any.)[3] Medicare has established specific rules governing its program payments for all covered services as well as for beneficiary cost sharing as described below.

Medicare Payment Rules

Medicare has established specific rules governing payment for covered services. For example, the program pays for most acute inpatient and outpatient hospital services, skilled nursing facility services, and home health care under a prospective payment system (PPS) established for the particular service; under PPS, a predetermined rate is paid for each unit of service such as a hospital discharge or payment classification group. Payments for physician services, clinical laboratory services, and certain durable medical equipment covered under Part B are made on the basis of fee schedules.[4] Certain other services are paid on the basis of reasonable costs or reasonable charges. In general, the program provides for annual updates of the program payments to reflect inflation and other factors. In some cases, these updates are linked to the consumer price index for all urban consumers (CPI-U) or to a provider-specific market basket (MB) index which

[1] Certain non-physicians providers (such as physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, psychologists, and social workers) are permitted to furnish services and bill Medicare under the physician fees schedule. In this report, the term "physician" or "practitioner" will include all such providers unless otherwise specified.

[2] Not all services require cost sharing from a beneficiary. For instance, clinical laboratory services and home health services under Parts A and B of Medicare do not require payments from a beneficiary or a beneficiary's insurance, such as Medicare supplemental insurance (Medigap), Medicaid, or employer-sponsored retiree health insurance. Cost-sharing requirements under Part C plans may differ from those under Parts A and B for the same service.

[3] For more information, see CRS Report R42745, *Medigap: A Primer*.

[4] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA) required the Secretary to establish and implement a competitive bidding program for durable medical equipment, prosthetics, orthotics and certain supplies. The program pays for certain items based on the bids of qualified suppliers in designated areas. Payment amounts based on competitive bidding are being used in the first nine competitive bidding areas as of January 1, 2012. See CRS Report R41211, *Medicare Durable Medical Equipment: The Competitive Bidding Program*.

measures the change in the price of goods and services purchased by the provider to produce a unit of output. However, updates to the physician fee schedule are determined by a statutory formula, known as the sustainable growth rate (SGR) system, which links annual updates to how cumulative actual expenditures compare with a cumulative expenditures target.[5]

Beneficiary Out-of-Pocket Payments

In addition to premiums, there are two aspects of beneficiary payments to providers: required cost-sharing amounts (either coinsurance, copayments, or deductibles) and the amounts that beneficiaries may be billed over and above Medicare's recognized payment amounts for certain services. Almost all persons age 65 and over are automatically entitled to premium-free Medicare Part A, as they, or their spouse, have at least 40 quarters of Medicare covered employment. For Part A, coinsurance and deductible amounts are established annually; these payments include deductibles and coinsurance for hospital services, coinsurance for skilled nursing facilities (SNFs), no cost sharing for home health services, and nominal cost sharing for hospice care.[6] For Part B, beneficiaries are generally responsible for monthly premiums, which range from $99.90 to $319.70 in 2012, depending on the beneficiary's income, a $140 deductible in 2012 (updated annually by the increase in the Part B premium), and a coinsurance payment of 20% of the established Medicare payment amounts.[7] For Part C, cost sharing is determined by the private plans. Through 2005, the total of premiums[8] for *basic* Medicare benefits and cost sharing (deductibles, coinsurance, and co-payments) charged to a Part C enrollee could not exceed actuarially determined levels of cost sharing for those same benefits under original Medicare. This meant that plans could not charge a premium for Medicare-covered benefits without reducing cost-sharing amounts. Beginning in 2006, the constraint on a plan's ability to charge a premium for *basic* Medicare benefits was lifted. The bidding mechanism established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allows plans to charge a premium to cover *basic* Medicare benefits if the costs to the plan exceed the maximum amount the Centers for Medicare & Medicaid Services (CMS) will pay for Medicare-covered benefits. The MMA eliminated the explicit inverse relationship between cost sharing for *basic* Medicare benefits and a premium for *basic* Medicare benefits. Aggregate enrollee cost sharing under Part C is now only constrained by the actuarial value of cost sharing under original Medicare.[9] However, also beginning in 2006, the Secretary has expanded authority to negotiate or

[5] For details, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*.

[6] In 2012, for each spell of illness, a beneficiary pays a deductible of $1,156 to cover day 1 through 60 in a hospital. The daily coinsurance charge is $289 for each day from 61 through 90. After 90 days in the hospital, a beneficiary may draw down 60 lifetime reserve days with a daily coinsurance of $578.

[7] Generally, Part B premiums are set to cover 25% of the actuarial cost of Part B services for an aged beneficiary. Income-related Part B premiums were introduced by the MMA and first took effect in 2007. For more information, see CRS Report R40082, *Medicare: Part B Premiums*.

[8] Through 2005, managed care plans had the option to charge a premium for basic Parts A and B Medicare benefits only if the value of cost sharing for basic benefits was reduced by the same amount. If a plan chose to offer supplemental benefits not covered under original Medicare, the plan could charge a supplemental premium equal to the actuarial value of supplemental benefits; the value of the supplemental premium was not constrained by cost-sharing levels for basic Medicare benefits. All beneficiaries in Part C and original Medicare are required to pay a Part B premium, unless the Part C plan pays-down the value of the Part B premium as part of a supplemental benefit.

[9] Plans must also adhere to specific constraints on enrollee cost-sharing. Beginning in 2011, cost sharing under an MA plan may not exceed that under original Medicare for certain services, such as chemotherapy treatment, renal dialysis, skilled nursing care and other services identified by the Secretary.

reject a bid from a managed care organization in order to ensure that the bid reasonably reflects the plan's revenue requirements. The base beneficiary premium under part D for 2012 is $31.08 per month; however, actual premiums vary by plan and are increased for beneficiaries with incomes above specified thresholds, similar to Part B premiums. Part D cost sharing includes a deductible, co-payments, and catastrophic limits on out-of-pocket spending.

For most services, there are rules on amounts beneficiaries may be billed over and above Medicare's recognized payment amounts. Under Part A, providers agree to accept Medicare's payment as payment in full and cannot bill beneficiaries amounts in excess of the coinsurance and deductibles. Under Part B, providers and practitioners are subject to limits on the amounts they can bill beneficiaries for covered services depending on their participation status in the Medicare program. A *participating physician* agrees to accept the approved fee schedule amount as payment in full (assignment) for all services delivered to Medicare beneficiaries, of which 80% is paid by the Medicare program and the beneficiary is responsible for the 20% coinsurance plus any unmet deductible. Physicians who do not agree to accept assignment on all Medicare claims in a given year are referred to as *nonparticipating physicians*. Nonparticipating physicians may or may not accept assignment for a given service. If they do not, they may charge beneficiaries more than the fee schedule amount on nonassigned claims; for physicians, these *balance billing* charges are subject to certain limits.

Assignment is mandatory for some providers, such as nurse practitioners, physician assistants, and clinical laboratories; these providers can only bill the beneficiary the 20% coinsurance and any unmet deductible. For other Part B services, such as durable medical equipment, assignment is optional; providers may bill beneficiaries for amounts above Medicare's recognized payment level and may do so without limit.

Recent Congressional Actions with Respect to Payments

Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been a major focus of legislative attention, as outlined below. With a few exceptions, savings in program spending have been achieved largely through reductions in the updates to provider payments, primarily hospitals, physicians, and MA plans. However, even when payments are frozen (as has been the case in some years with payments to acute care hospitals, inpatient rehabilitation facilities, long term care hospitals, and with the physician fee schedule), Medicare spending continues to increase each year as the number of beneficiaries increases, and the number and complexity of services becomes greater.[10]

The Patient Protection and Affordable Care Act (P.L. 111-148 as amended, ACA), is estimated to achieve substantial program savings through, permanent reductions in the maximum amount paid to MA plans, and reductions in the annual updates to Medicare's fee-for-service (FFS) providers (other than physicians' services), among other provisions. The anticipated savings from payment changes to FFS providers is substantially due to the application of a productivity adjustment. (Productivity, in general, is a measure of output produced relative to the amount of work required

[10] See CRS Report R41436, *Medicare Financing*.

to produce it.[11]) The ACA productivity adjustment marks a departure from most previous legislative actions to reduce Medicare program spending in two specific respects. First, it is a permanent, rather than time-limited, adjustment to (non-physician) payment updates.[12] Second, in general, it specifies that the adjustment allows for negative payment updates and as such, payment rates for a year may be less than for a preceding year. At the time of passage, the ACA was estimated to achieve net Medicare savings of approximately $430 billion over the 10-year budget window (FY2010-FY2019), based on a CRS analysis of the Congressional Budget Office estimates for provisions affecting the Medicare program.[13]

Though the ACA payment changes to Medicare providers and plans is expected to slow the growth in Medicare spending and extend the solvency of the Hospital Insurance (Part A) Trust Fund,[14] some have suggested that such a policy may not be sustainable in the long run, "without unprecedented improvements in health care provider productivity."[15] Once the impact of the provider payment changes from the ACA is known, Congress may wish to revisit the issue of the productivity adjustments to determine whether rates are much higher or much lower than originally estimated. As in the case of physician payment updates, it is unclear whether Congress will allow providers to be paid less under this new provision.

In addition, the ACA created an Independent Payment Advisory Board (IPAB), and charged it with developing proposals to "reduce the per capita rate of growth in Medicare" if spending goes above targets specified in the statute. IPAB is prohibited from recommending changes that would reduce payments to certain providers before 2020 and is also prohibited from recommending changes in premiums, benefits, eligibility and taxes or other changes that would result in rationing.[16] Unlike other agencies that advise Congress, IPAB's recommendations are to be automatically implemented unless Congress acts. Congress can alter the Board's proposals,

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[11] For a general discussion on productivity measurement and growth, see CRS Report RL34677, *Productivity Growth: Trends and Prospects*. For a detailed description of the productivity adjustment as it applies to Medicare FFS providers, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

[12] The Balanced Budget Act of 1997 first introduced the concept of productivity-adjusted payment increases for physician services, however, Congress has overridden the effects of the productivity adjustment in recent years. For more information, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*.

[13] Net Medicare program savings include direct spending cost reductions (such as reductions in provider payment rate updates) and cost increases (such as an increase in the Part D low-income subsidy), as well as interactive effects where a direct change to one part of the program are expected to have an impact on other parts. However, the cost of repealing ACA provisions would not necessarily be the inverse of the savings originally estimated for those provisions. The Congressional Budget Office estimates that repeal of the ACA (including the productivity adjustments) would increase Medicare spending by $716 billion over the 10-year period FY2013-2022. CBO, July 24, 2012 letter to Speaker Boehner on the direct spending and revenue effects of H.R. 6079, the Repeal of Obamacare Act, as passed by the House of Representatives on July 11, 2012, http://cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf. See also, Patricia Davis, *Estimates of Medicare Savings in the Patient Protection and Affordable Care Act*, Congressional Research Service, General Distribution Memorandum, August 31, 2012, p. 6, available upon request.

[14] CRS Report R41436, *Medicare Financing*.

[15] 2012 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund, p. 3, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf.

[16] Providers and suppliers scheduled to receive additional reductions beyond an annual productivity adjustment under ACA receive a time-limited exemption from IPAB's recommendations (if any are made). These exclusions leave payments for MA and Part D drug plan, critical access hospital, SNF, home health, dialysis, ambulance, ambulatory surgery center services, and durable medical equipment (DME) subject to IPAB recommendations.

within limitations, or discontinue the automatic implementation of proposals.[17] The Board is to be appointed by the President in consultation with congressional leadership and with the advice and consent of the Senate. It is to submit its first set of recommendations to the President and to Congress, if required, by January 15, 2014.[18]

Provisions in the Budget Control Act of 2011 (P.L. 112-25, BCA) are expected to impact Medicare payments. The BCA established a Joint Select Committee on Deficit Reduction and tasked it with providing to Congress by November 23, 2011 recommendations on ways to reduce the deficit over the subsequent 10 years. When the Committee did not provide the recommendations, this triggered a government-wide sequestration process to reduce Federal spending beginning in 2013.[19] Without further legislative action, payments for most Medicare benefits will be subject to a maximum 2% reduction each year from 2013 through 2021. For payments made to providers and suppliers under Medicare Parts A and B, the percentage reduction applies to individual payments for items and services provided. In the case of Medicare Parts C and D, reductions are made to the monthly payments made to the private plans that administer these parts of the program. Certain parts of Medicare, however, are exempt from sequestration. These include (1) the Part D low-income subsidies;[20] (2) the Part D catastrophic subsidy; and (3) Qualified Individual (QI) premiums. Outlays for certain Medicare administrative expenditures (non-benefit spending) could be subject to reductions of greater than 2%. Provider-specific sequestration adjustments are not reflected in the tables that follow, in part, because the estimates and clarifications provided by the administration remain "preliminary."[21]

Most recently, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA, P.L. 112-78), and the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, P.L. 112-96) both extended certain time-limited payment adjustments to specified Medicare providers.[22]

This report provides a guide to Medicare payment rules by type of benefit. The information is presented through a series of tables, each representing a provider type, such as physicians, or Medicare Advantage plans. The first column in each table lists the type of payments that may be received by the provider (e.g., the separate operating and capitol payments paid to short-term general hospitals under the prospective payment system as described in **Table 1**), or lists subcategories of providers under the general provider category (such as the different types of non-physician providers that are all listed in **Table 7**). The second column of each table discusses the general policy for determining payments while column three describes how the general payment amounts are updated, or adjusted each year (e.g., amounts may be updated by a measure of inflation, economy-wide productivity, or statutorily specified reductions to updates). The final column presents the most recent update amounts. This report is updated to reflect the most recent legislative changes to the program and payment updates available through September 2012.

[17] The Board, at various times, will also develop advisory reports on the Medicare program and on ways to slow the growth of national health expenditures; these advisory reports are not automatically implemented.

[18] For more information, see CRS Report R41511, *The Independent Payment Advisory Board*.

[19] CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*.

[20] See CRS Report R40425, *Medicare Primer* for an overview of the Medicare Part D benefit.

[21] Executive Office of the President, *OMB Report Pursuant to the Sequestration Transparency Act of 2012 (P.L. 112-155)*, September 14, 2012, p. 1, http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/stareport.pdf.

[22] For more information, see Jim Hahn, et al., *Medicare and Medicaid Expiring Provisions*, Congressional Research Service, General Distribution Memorandum, August 24, 2012, available upon request.

Selected Acronyms and Public Law Numbers of Laws that have Amended Medicare Since 1997	
BBA97	The Balanced Budget Act of 1997 (P.L. 105-33, BBA 97).[23]
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), was part of a larger measure known as the Consolidated Appropriations Act for 2000 (P.L. 106-113).[24]
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), part of the larger Consolidated Appropriations Act, 2001 (P.L. 106-554).[25]
P.L. 108-7	Consolidated Appropriations Resolution, 2003.[26]
MMA	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA).[27]
DRA	The Deficit Reduction Act of 2005 (P.L. 109-171, DRA).[28]
TRHCA	The Tax Relief and Health Care Act of 2006 (P.L. 109-432, TRHCA).
P.L. 110-48	An act to provide for the extension of transitional medical assistance (TMA) and the abstinence education program through the end of fiscal year 2007, and for other purposes.[29]
P.L. 110-90	TMA, Abstinence Education, and QI Programs Extension Act of 2007.[30]
MMSEA	The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173, MMSEA).[31]
MIPPA	The Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275, MIPPA).[32]
HITECH	The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5).[33]

[23] For more information, see CRS Report 97-802, *Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)*.

[24] For more information, see CRS Report RL30347, *Medicare: Changes to Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) Provisions*.

[25] For more information, see CRS Report RL30707, *Medicare Provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554)*.

[26] This public law does not have a commonly used acronym.

[27] For more information, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*.

[28] For more information, see CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*.

[29] This public law does not have a commonly used acronym.

[30] This public law does not have a commonly used acronym.

[31] For more information, see CRS Report RL34360, *P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007*.

[32] For more information, see CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*.

[33] The HITECH Act established a Medicare incentive program to encourage the widespread adoption of electronic health record (EHR) technology. The program provides incentive payments to acute care hospitals, critical access hospitals (CAHs), and nonhospital-based physicians that demonstrate "meaningful use" of EHR technology by using their EHR systems to perform specified functions to improve the quality of care. Those functions include recording certain demographic and medical information about patients, exchanging electronic health information, and reporting clinical quality measures. The HITECH Act instructs the Secretary over time to establish more stringent measures of meaningful use. Eligible physicians can receive up to $44,000 over five years. Incentive payments to hospitals, payable over a four-year period, are based on a formula that includes a $2 million base payment plus an additional discharge-related amount, adjusted for the hospital's Medicare patient share and charity care. Since the program began in 2011, more than $3.2 billion in Medicare EHR incentive payments have been made to physicians and hospitals across the United States. Beginning in 2015, physicians and hospitals that are not meaningful EHR users will be subject to a payment adjustment (i.e., penalty). CMS maintains an extensive website on the Medicare and Medicaid EHR incentive programs, with links to fact sheets and other resources for providers, as well as detailed statistics on incentive payments (continued...)

ACA	The Patient Protection and Affordable Care Act (P.L. 111-148) as modified by the Health Care and Education Reconciliation Act (P.L. 111-152, referred to collectively as ACA).[34]
P.L. 111-309	The Medicare and Medicaid Extenders Act of 2010.[35]
BCA	The Budget Control Act of 2011 (BCA, P.L. 112-25).[36]
TPTCCA	The Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA, P.L. 112-78).
MCTRJCA	The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, P.L. 112-96).

(...continued)

by program, state, and type of provider, at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html. For more information, see CRS Report R40181, *Selected Health Funding in the American Recovery and Reinvestment Act of 2009*.

[34] For more information, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

[35] This public law does not have a commonly used acronym.

[36] CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*.

Medicare Payment Policies

Part A

Table 1. Inpatient Prospective Payment System (IPPS) for Short-term, General Hospitals

Provider/service	General payment policy	General update policy	Recent update
Operating PPS for inpatient services provided by acute hospitals (Operating IPPS)	Medicare pays acute care hospitals using a prospectively determined payment for each discharge. A hospital's payment for its operating costs is calculated using a national standardized amount adjusted by a wage index associated with the area where the hospital is located or where it has been reclassified. Payment also depends on the relative resource use associated with the diagnosis related group (DRG) to which the patient is assigned. A new Medicare Severity DRG (MS-DRG) patient classification system was phased in starting in FY2008; that transition is now complete. Medicare pays additional amounts for cases with extraordinary costs (outliers); indirect medical education (IME) (see below); and for hospitals serving a disproportionate share (DSH) of low-income patients (see below). IME and DSH payments are made through adjustments to IPPS so that hospitals receive more money for each Medicare discharge. Certain low volume hospitals receive additional payments as well. ACA made the existing low volume adjustment more generous for FY2011 and FY2012 only. Starting in FY2013, hospitals with higher than expected readmissions are subject to as much as a 1% penalty. Additional payments may be made for cases that involve qualified new technologies that have been approved for special add-on payments. Hospitals in Hawaii and Alaska receive a cost-of-living adjustment (COLA). The cost of certain	After accounting for certain budget neutrality adjustments, IPPS payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket (MB) index. This is a fixed price index that measures the change in the price of goods and services purchased by hospitals to create one unit of output. The update for operating IPPS is established by statute. Under DRA, hospitals that do not submit required quality data in FY2007 and each subsequent year will have the applicable MB percentage reduced by two percentage points. Any MB reduction does not apply when computing the applicable percentage increase in subsequent years. Starting in FY2015, the reporting penalty will be 25% of the update factor. The HITECH Act established update penalties for hospitals that are not meaningful electronic health record (EHR) users starting in FY2015. Specifically, these hospitals will have an update reduction of 25% in FY2015, 50% in FY2016, and 75% in FY2017 and in subsequent years. ACA established a schedule of annual reductions in the update for FY2009 through FY2019. The annual update includes a productivity adjustment starting October 1, 2011. The ACA update reductions may result in a negative update for that year. This update is then subject to other budget neutrality and other policy adjustments. In its FY2008 rule, CMS established prospective budget neutrality adjustments of -1.2% in FY2008,	**For FY2012**, hospitals that submitted the required quality data had a national standardized amount of $5,209.74. Hospitals that did not submit the quality data had a national standardized amount of $5,107.49. In FY2012, the MB increase of 3.0% was reduced by a 1.0% multifactor productivity adjustment and then reduced by the ACA adjustment of 0.1% for a net increase of 1.9%. This update was then increased by 1.1% due to litigation concerning the rural floor budget neutrality factor and then decreased by the prospective coding adjustment of 2.0% for a net increase of 1.0% before the application of budget neutrality and other policy adjustments (such as a 2.0% reduction for hospitals that did not submit required quality data). **For FY2013**, hospitals that submitted the required quality data have a national standardized amount of $5,328.76. Hospitals that did not submit the quality data have a national standardized amount of $5,243.67. In FY2013, the MB increase of 2.6% is reduced by a 0.7% multifactor productivity adjustment and then reduced by the ACA adjustment of 0.1% for a net increase of 1.8% before the application of budget neutrality and other policy adjustments (such as a 2.0% reduction for hospitals that did not submit required quality

Provider/service	General payment policy	General update policy	Recent update
	services, including Medicare beneficiaries' bad debt, are reimbursed outside of IPPS. MCTRJCA reduced reimbursement on bad debt for hospital services provided to beneficiaries from 70% to 65%, starting in FY2013.	-1.8% in FY2009 and -1.8% in FY2010 because of anticipated increases in measured severity of illness attributable to coding changes or documentation improvements (coding creep) associated with the new MS-DRGs. P.L. 110-90 reduced the adjustment to -0.6% in FY2008 and -0.9% in FY2009, but permitted offsets to IPPS rate increases in FY2010, FY2011, and FY2012 to account for coding creep increases in FY2008 and FY2009 above these amounts. The law did not address the scheduled adjustment of an additional 1.8% decrease in FY2010. However, in FY2010, CMS did not adjust the update for coding improvements. In FY2011, CMS estimated that an additional 5.8% adjustment was warranted for the coding improvements that increased payments in FY2008 and FY2009 (to recoup payments retroactively). Also, an additional 3.9% adjustment was necessary to eliminate the full effect of coding improvements on future payments (a prospective adjustment). CMS reduced the FY2011 update by 2.9%, half the amount of the retroactive recoupment adjustment. In FY2012, CMS implemented the remainder of the 2.9% retroactive adjustment (after adding back the 2.9% reduction from the earlier year). CMS also implemented a 2.0% prospective reduction (leaving a 1.9% prospective adjustment for future years). In FY2013, the documentation and coding improvements for FY2008 and FY2009 are completed by reversing (or adding) the 2.9% adjustment for FY2012, which is offset by a negative 1.9% adjustment. The FY2013 documentation and coding adjustment is 1.0%.	data). The increase is subject to budget neutrality adjustments to correct for MS-DRG recalibrations, wage index changes, hospital reclassifications, documentation and coding improvements as well as to fund outlier payments and the Rural Community Demonstration program.
Capital IPPS for short-term general hospitals (Capital IPPS)	Medicare's capital IPPS is structured similarly to its operating IPPS for short-term general hospitals. A hospital's capital payment is based on a prospectively determined federal payment rate, depends on the DRG to which the patient is assigned, and is adjusted by a hospital's geographic adjustment factor (which is calculated from the hospital's wage index data). Capital IPPS includes an IME and DSH adjustment (see	Updates to the capital IPPS are not established in statute. Capital rates are updated annually by the Centers for Medicare & Medicaid Services (CMS) according to a framework which considers changes in the prices associated with capital-related costs as measured by the capital input price index (CIPI) and other policy factors, including changes in case mix intensity, errors in previous CIPI forecasts, DRG recalibration, and DRG reclassification. Other	The capital IPPS update for **FY2012** was 1.5%. After adjustments, the FY2012 capital federal rate was $421.42 for discharges starting October 1, 2011. The capital IPPS update for **FY2013** is 1.2%, which reflects an estimated increase in the CIPI of 1.2%; the FY2013 federal capital rate is $425.49.

Provider/service	General payment policy	General update policy	Recent update
	below). Starting in FY2008, the IME adjustment will be phased out over a 3-year period. Additional payments are made for outliers (cases with significantly higher costs above a certain threshold). Certain hospitals may also qualify for additional payments under an exceptions process. A new hospital is paid 85% of its allowable Medicare inpatient hospital capital-related costs for its first two years of operation.	adjustments include those that implement budget neutrality with respect to recalibration of DRGs, documentation and coding changes resulting from the switch to MS-DRGs that do not reflect real changes in patient severity of illness, real outlier payments, changes in the geographic adjustment factor, and exception payments. The capital update increase was reduced by 2.9% in FY2011 and by 1.0% in FY2012 to account for coding improvements.	

Provider/service	General payment policy	General update policy	Recent update
Disproportionate share hospital (DSH) adjustment	Approximately 2,800 hospitals receive the additional payments for each Medicare discharge based on a formula which incorporates the number of patient days provided to low-income Medicare beneficiaries (those who receive Supplemental Security Income (SSI)) and Medicaid recipients. A few urban hospitals, known as "Pickle Hospitals," receive DSH payments under an alternative formula that considers the proportion of a hospital's patient care revenues that are received from state and local indigent care funds. The percentage add-on for which a hospital will qualify varies according to the hospital's bed size or urban or rural location. The DSH adjustment for most categories of hospitals is capped at 12%. Urban hospitals with more than 100 beds, rural hospitals with more than 500 beds, Medicare dependent hospitals (MDHs, see below), and rural referral centers (RRC, see below) are exempt from the 12% DSH adjustment cap.	No specific update. The amount of DSH spending in any year is open-ended and varies by the number of Medicare discharges as well as the type of patient seen in any given hospital.	CBO estimates DSH spending (in both operating and capital payments) at $10.5 billion in **FY2011** and $10.8 billion in **FY2012** (March 2012 baseline).
Indirect Medical Education (IME) adjustment	The indirect medical education (IME) adjustment is one of two types of payments to teaching hospitals for graduate medical education (GME) costs (see also direct GME below). Medicare increases both its operating and capital IPPS payments to teaching hospitals; different measures of teaching intensity are used in the operating and capital IPPS. For both IPPS payments, however, the number of medical residents who can be counted for the IME adjustment is capped, based on the number of medical residents as of December 31, 1996. As established by BBA 97, teaching hospitals also receive IME payments for their Medicare Part C discharges. (See also Medicare Part C below.)	The IME adjustment is not subject to an annual update. BBA 97 reduced the IME adjustment in operating IPPS from a 7.7% increase for each 10% increase in a hospital's ratio of interns to beds (IRB), a measure of teaching intensity in operating IPPS; by FY2001, the IME adjustment was to be 5.5%. However, the scheduled decreases were delayed by subsequent legislation. As established by MMA, the IME adjustment was set at 5.5% in FY2008 and subsequently.	No specific update. The amount spent on IME depends in part on the number of Medicare discharges in teaching hospitals in any given year. CBO estimates the IME payments (for both capital and operating payments) to be about $6.2 billion in **FY2011** and $6.3 billion in **FY2012** (March 2012 baseline).
Direct graduate medical education (direct GME) payments	Direct GME costs are excluded from IPPS and paid outside of the DRG payment on the basis of updated hospital-specific costs per resident amount (PRA), the number of weighted full-time equivalent (FTE) residents, and Medicare's share	In general, direct GME payments are updated by the increase in the consumer price index for all urban consumers (CPI-U). As established by BBRA and subsequently amended, however, the update amount that any hospital receives depends upon	Hospitals below 140% of the national average from FY2004-FY2013 receive an update of CPI-U. Hospitals above 140% of the national average for that time period will receive no update. CBO estimates direct GME payments

Provider/service	General payment policy	General update policy	Recent update
	of total patient days in the hospital (including those days attributed to Medicare managed care enrollees). There is a hospital-specific cap on the number of residents in the hospital for direct GME payments. Also, the hospital's FTE count is based on a three-year rolling average; a specific resident may count as half of a FTE, depending on the number of years spent as a resident and the length of the initial training associated with the specialty. Certain combined primary care residency programs receive special recognition in this count. In certain circumstances, direct GME payments can be made to nonhospital providers.	the relationship of its PRA to the national average PRA. Hospitals with PRAs below the floor (85% of the locality-adjusted, updated, and weighted national PRA) are raised to the floor amount. Teaching hospitals with PRAs above the ceiling amount (140% of the national average, adjusted for geographic location) will receive a lower update than other hospitals (CPI-U minus two percentage points) for FY2003-FY2013. Hospitals that have PRAs between the floor and ceiling receive the CPI-U as an update amount.	of $2.7 billion in **FY2011** and $2.8 billion in **FY2012** (March 2012 baseline).

Table 2. Hospitals Receiving Special Consideration Under Medicare's IPPS

Provider/service	General payment policy	General update policy	Recent update
Sole Community Hospitals (SCHs)—facilities located in geographically isolated areas and deemed to be the sole provider of inpatient acute care hospital services in a geographic area based on distance, travel time, severe weather conditions, and/or market share as established by specific criteria set forth in regulation (42 CFR 412.92).	An SCH receives the higher of the following payment rates as the basis of reimbursement: the current IPPS base payment rate, or its hospital-specific per-discharge costs from either FY1982, 1987, or 1996, updated to the current year. Under MIPPA, for cost reporting periods beginning on or after January 1, 2009, an SCH can elect payment based on its FY2006 hospital-specific payment amount per discharge. This amount is increased by the annual update starting for discharges on or after January 1, 2009. An SCH may receive additional payments if the hospital experiences a decrease of more than 5% in its total inpatient cases due to circumstances beyond its control. An SCH receives special consideration for reclassification into a different area. Starting for services on January 1, 2006, CMS increased outpatient prospective payment system (OPPS) payments to rural SCHs by an additional 7.1%.	Target amounts for SCHs are updated by an "applicable percentage increase" which is specified by statute and is often comparable to the IPPS update. (See description for IPPS hospitals).	**For FY2012**, the hospital-specific amount for SCHs that submitted the required quality data received the full MB increase of 3.0% which was then reduced by 2.0% to account for coding improvements. The update to the hospital specific amount for SCHs that did not submit the quality data was reduced by another 2 percentage points. **For FY2013**, the hospital-specific amount for SCHs that submit the required quality data receive a full MB increase of 2.6%, which is subject to a 0.5% reduction to account for coding improvements in FY2008 and FY2009. The update for those that do not submit quality data is subject to the 2 percentage point reduction.
Rural Referral Centers (RRCs)—relatively large hospitals, generally in rural areas, that provide a broad array of services and treat patients from a wide geographic area as established by specific criteria set forth in regulation. (42 CFR 412.96).	RRCs payments are based on the IPPS for short-term general hospitals. RRCs are exempt from the 12% DSH adjustment cap. Also, RRCs receive preferential consideration for reclassification to a different area.	RRCs receive the operating and capital IPPS updates specified for short-term general hospitals.	See updates specified for operating and capital IPPS for short-term general hospitals.

Table 3. IPPS-Exempt Hospitals and Distinct Part Units

Provider/service	General payment policy	General update policy	Recent update
Inpatient Rehabilitation Facilities (IRFs)—freestanding hospitals and hospital-based distinct part units that treat a percentage of patients with a defined set of conditions and meet certain established conditions of participation. As established by MMSEA, starting July 1, 2007, the IRF compliance threshold (which determines whether a facility is an IRF or an acute care hospital) is set at 60%; comorbidities are included as qualifying conditions. To be paid as an IRF, an entity must have 60% of its inpatients with one of 13 conditions including stroke, spinal cord injury, brain injury, neurological disorder, burns, and certain arthritis related conditions.	As of January 1, 2002, Medicare's payments to a rehabilitation facility are based on a fully implemented IRF-PPS and 100% of the federal rate which is a fixed amount per discharge. This PPS encompasses both capital and operating payments to IRFs, but does not cover the costs of approved educational programs, bad debt expenses, or blood clotting factors, which are paid for separately. The IRF-PPS payment for any Medicare discharge will vary depending on the patient's impairment level, functional status, comorbidity conditions, and age. These factors determine which of the 87 Case Mix Groups (CMGs) is assigned to the inpatient stay. Within each of these CMGs, patients are further assigned to one of four tiers based on any comorbidities they may have. Five other CMGs are used for patients discharged before the fourth day (short stay outliers) and for those who die in the facility. Generally, IRF payments are reduced or increased for certain case level adjustments, such as early transfers, short-stay outliers, patients who die before transfer, and high cost outliers. Payments also depend upon facility-specific adjustments to accommodate for variations in area wages, percentage of low income patients (LIP) served by the hospital (a DSH adjustment), and rural location (rural IRFs receive increased payments, about 19% more than urban IRFs.) Starting in FY2006, an IME adjustment is included; IRFs in Alaska and Hawaii do not receive a COLA adjustment. The IRF-PPS is not required to be budget neutral; total payments can exceed the amount that would have been paid if this PPS had not been implemented. MCTRJCA reduced reimbursement on bad debt for IRF services provided to beneficiaries from 70% to 65%, starting in FY2013.	Starting in FY2006, the IRF-PPS update is based on the MB derived from the cost reports of rehabilitation, psychiatric, and long-term care hospitals (RPL-MB); in FY2012 the RPL-MB was revised and rebased to reflect FY2008 data. The RLP-MB includes an update estimate for capital as well as operating costs. MMSEA established the IRF update factor at 0% in FY2008 and FY2009, starting for discharges on April 1, 2008. ACA established a schedule of annual reductions in the update for FY2010 through FY2019. The FY2013 update reduction is 0.1 percentage point. The annual update also includes a productivity adjustment starting October 1, 2011. Under ACA, update reductions may result in a negative update for that year.	The **FY2012** IRF-PPS update was the MB of 2.9% reduced by a 1.0 percentage point productivity adjustment, the ACA adjustment of 0.1 percentage point and other budget neutrality adjustments. The final FY2012 standard conversion factor for IRFs was $14,076. The **FY2013** IRF-PPS update is the MB of 2.7% reduced by a 0.7 percentage point productivity adjustment, the ACA adjustment of 0.1 percentage point, and other budget neutrality adjustments. The final FY2013 standard conversion factor for IRFs is $14,343.

Provider/service	General payment policy	General update policy	Recent update
Long-Term Care Hospitals and satellites or onsite providers (LTCHs)—acute general hospitals that are excluded from IPPS with a Medicare inpatient average length of stay (ALOS) greater than 25 days and meet certain facility criteria established by MMSEA.	Effective October 1, 2002, LTCHs are paid on a discharge basis under a DRG-based PPS, subject to a five-year transition period. The LTCH-PPS encompasses payments for both operating and capital-related costs of inpatient care but does not cover the costs of approved educational programs, bad debt expenses, or blood clotting factors which are paid for separately. The LTCH-PPS payment for any Medicare discharge will vary depending on the patient's assignment into a Medicare severity (MS) LTC-DRG. MS-LTC-DRGs are based on reweighted IPPS MS-DRGs. Payments for specific patients may be increased or reduced because of case-level adjustments, such as short stay cases, interrupted stay cases, readmitted cases from co-located providers and high costs outliers. Payments also depend upon facility-specific adjustments such as variations in area wages and include a COLA for hospitals in Alaska and Hawaii. No adjustments are made for the percentage of low income patients served by the hospital (DSH), rural location, or IME. The LTCH-PPS is required to be budget neutral; total payments must equal the amount that would have been paid if the PPS had not been implemented. MMSEA imposed a moratorium on this budget neutrality adjustment and other LTCH regulations including one that established Medicare's payments for very short stay outliers. The moratoria have been subsequently extended but will lapse starting December 29, 2012. MCTRJCA reduced reimbursement on bad debt expenses for LTCH services provided to beneficiaries from 70% to 65%, starting in FY2013.	The LTCH update is not specified in statue. Until FY2013, CMS increased the LTCH rates based on the most recent estimate of the rehabilitation, psychiatric, and long-term care (RPL) market basket adjusted to account for improved coding practices. Starting in FY2013, CMS has implemented an LTCH specific MB as the basis for its update policy. CMS changed the effective date of the annual update from October 1 (the beginning of the fiscal year) to July 1 of each year (referred to as a rate year), starting July 2003. In the rate year (RY) for 2009 final rule, CMS changed the effective date of the annual update back to October 1, beginning October 1, 2009. CMS adopted the term fiscal year rather than rate year beginning October 1, 2010. ACA established a schedule of annual reductions in the update for RY2010 through RY2019. The reduction in the RY2010 update of 0.25 percentage point became effective for discharges starting April 1, 2010. CMS established a fiscal year schedule (October 1st) for the ACA adjustments, starting in 2011. The FY2012 update reduction is 0.1 percentage point. The update will include a productivity adjustment starting October 1, 2011. The ACA update reductions may result in a negative update for that year. For FY2013, CMS determined that a one-time prospective budget neutrality adjustment of 3.75% (0.9625) will be permanently applied to the federal payment rate over a three year period, starting for discharges December 29, 2012. Starting in FY2014, LTCHs that do not comply wit the LTCH quality reporting program will have their annual updates reduced by 2 percentage points.	In **FY2012** (starting October 1, 2011) the LTCH federal payment rate was increased by a 2.9% MB update reduced by a productivity adjustment of 1.0 percentage point and the ACA reduction of 0.1 percentage point. The update factor of 1.8% was subject to budget neutrality adjustments but not a coding improvement reduction. The LTCH federal payment rate is set at $40,222.05 for discharges starting on October 1, 2011. In **FY2013** (starting October 1, 2012) the LTCH federal payment rate is increased by a 2.6% MB update reduced by a productivity adjustment of 0.7 percentage points and the ACA reduction of 0.1 percentage point. The update factor of 1.8% will be subject to the phased-in one time budget neutrality adjustment of approximately -1.3% starting for discharges on December 29, 2012. The LTCH federal payment rate is set at $40,915.95 for discharges starting on October 1, 2012 through December 28, 2012. Starting December 29, 2012, the LTCH federal payment rate will be $40,397.96.

Provider/service	General payment policy	General update policy	Recent update
Psychiatric hospitals and distinct part units—include those primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of people with mental illness.	Starting January 1, 2005, Medicare pays for services provided in inpatient psychiatric facilities (IPF) using a per-diem based PPS. Established with a three-year transition period, the IPF-PPS incorporates patient-level adjustments for specified DRGs, selected comorbidies, and in certain cases, age of the patient. Facility-level adjustments for relative wages, teaching status, and rural location are also included. IPFs in Hawaii and Alaska will receive a COLA adjustment. Medicare per diem payments are higher in the earlier days of the psychiatric stay. Also, the per diem payment for the first day of each stay is 12% higher in IPFs with qualifying (full-service) emergency departments than in other IPFs. An outlier policy for high-cost cases is included. Patients who are discharged from an IPF and return within three days are considered readmissions of the same case. IPFs also receive an additional payment for each eletroconvulsive therapy treatment furnished to a patient. The cost of certain services, including Medicare beneficiaries' bad debt, are reimbursed outside of IPF-PPS. MCTRJCA reduced reimbursement on bad debt for hospital services provided to beneficiaries from 70% to 65%, starting in FY2013.	The IPF update is not specified in statue. CMS has established a policy to update the per diem rates based on the most recent estimate of the rehabilitation, psychiatric, and long-term care market basket (RPL-MB). ACA established a schedule of annual reductions in the update starting RY2011 through RY2020. The reduction in the RY2011 IPF update of 0.25 percentage points was effective July 1, 2010. The update will include a productivity adjustment starting July 1, 2012. The ACA update reductions may result in a negative update for that year. In RY2011, CMS shifted IPFs from a July 1st rate setting cycle to an October 1st. fiscal year cycle. To make that change, the IPF PPS RY2012 was established as a 15 month period from July 1, 2011 to September 30, 2012. In FY2013, CMS finalized a new quality data reporting program for IPFs that would reduce the IPF-PPS annual payment update by 2.0 percentage points for IPFs that do not comply with quality data submission requirements, starting for the FY2014 payment update.	CMS shifted IPFs to an October 1st rate setting cycle starting July 1 2011. To make the change, CMS established a 15 month RPL-MB update starting RY2012 (on July, 1, 2011) at 3.2%. After applying a wage index budget neutrality factor of 0.9995 and the ACA offset of 0.25 percentage point, the federal base payment is $685.01 per day until September 30, 2012. In **FY2013**, the IPF per diem is increased by a 2.7 MB update reduced by a productivity adjustment of 0.7 percentage points, an ACA adjustment of 0.1 percentage point and other budget neutrality adjustments. The FY2013 IPF per diem amount is $698.51.

Provider/service	General payment policy	General update policy	Recent update
Children's and cancer hospitals: ***Children's hospitals*** are those engaged in furnishing services to inpatients who are predominantly individuals under the age of 18. ***Cancer hospitals*** are generally recognized by the National Cancer Institute as either a comprehensive or clinical cancer research center; are primarily organized for the treatment of and research on cancer (not as a subunit of another entity); and have at least 50% of their discharges with a diagnosis of neoplastic disease. See 42 CFR 412.23(f).	Children's and cancer hospitals are paid on a reasonable cost basis, subject to TEFRA payment limitations and incentives. Each provider's reimbursement is subject to a ceiling or target amount that serves as an upper limit on operating costs. Depending upon the relationship of the hospital's actual costs to its target amount, these hospitals may receive relief or bonus payments as well as additional bonus payments for continuous improvement (i.e., facilities whose costs have been consistently less than their limits may receive additional money). Newly established hospitals receive special treatment. Providers that can demonstrate that there has been a significant change in services and/or patients may receive exceptions payments. The capital costs for these hospitals are reimbursed on a reasonable cost basis. MCTRJCA reduced reimbursement on bad debt for hospital services provided to beneficiaries from 70% to 65%, starting in FY2013.	An update factor for reimbursement of operating costs is established by statute. Starting in FY2006, the IPPS operating MB increase is used to update the target amounts. The amount of increase received by any specific hospital will depend upon the relationship of the hospital's costs to its target amount. There is no specific update for capital costs.	The update for **FY2012** was 3.0%. The update for **FY2013** is 2.6%.

Provider/service	General payment policy	General update policy	Recent update
Critical Access Hospitals (CAHs) are limited-service facilities that are located more than 35 miles from another hospital (15 miles in certain circumstances) or designated by the state as a necessary provider of health care; offer 24-hour emergency care; have no more than 25 acute care inpatient beds and have a 96-hour average length of stay. Beds in distinct-part skilled nursing facility, psychiatric or rehabilitation units operated by a CAH do not count toward the bed limit.	Medicare pays CAHs on the basis of the reasonable costs of the facility for inpatient and outpatient services. CAHs may elect either a cost-based hospital outpatient service payment or an all-inclusive rate which is equal to a reasonable cost payment for facility services plus 115% of the fee schedule payment for professional services. Ambulance services that are owned and operated by CAHs are reimbursed on a reasonable cost basis if these ambulance services are 35 miles from another ambulance system. MMA provided that inpatient, outpatient, and swing bed services provided by CAHs are paid at 101% of reasonable costs for cost reporting periods beginning January 1, 2004. Starting July 1, 2009, clinical diagnostic laboratory services furnished by a CAH are paid as outpatient hospital services at 101% of costs without regard to whether the individual is physically present in the CAH, or in a SNF or a clinic (including a rural health clinic) that is operated by a CAH at the time the specimen is collected. MCTRJCA reduced reimbursement on bad debt for CAH services provided to beneficiaries from 100% to 88% in FY2013, 76% in FY2014, and 65% in FY2015 and subsequent fiscal years.	No specific update policy.	No specific update policy.

Table 4. Skilled Nursing Facility (SNF) Care

Provider/service	General payment policy	General update policy	Recent update
Skilled Nursing Facility (SNF) care	SNFs are paid through a prospective payment system (PPS) which is composed of a daily ("per diem") urban or rural base payment amount adjusted for case mix and area wages. The **per diem** payment is intended to cover all the services provided to the beneficiary that day, including room and board, nursing, therapy, and prescription drugs. Some costs are excluded from PPS and paid separately such as physician visits, dialysis, and certain high cost prosthetics and orthotics. The case-mix adjustment to the base per diem rate adjusts payments for the treatment and care needs of beneficiaries and categorizes individuals into groups called resource utilization groups (RUGs). **The RUGs system** uses patient assessments to assign a beneficiary to one of 66 categories and to determine the payment for the beneficiary's care. Patient assessments are done at various times during a patient's stay and his or her RUG may change. The per diem is also adjusted to account for area wage variation, using the hospital wage index. Starting in FY2005, MMA increased payments for **AIDS patients** in SNFs by 128%. Unlike other PPSs, the SNF PPS statute does not include an adjustment for extraordinarily costly cases (an "outlier" adjustment). MCTRJCA reduced reimbursement on beneficiaries' bad debt for SNF services from 70% to 65%, starting in FY2013. Bad debt reimbursement for SNF services provided to a beneficiary is reduced from 100% to 88% in FY2013, 76% in FY2014, and 65% in FY2015 and subsequent fiscal years.	The urban and rural federal **per diem** payment rates are increased annually by an update factor determined, in part, by the projected increase in the SNF market basket (MB) index. This index measures changes in the costs of goods and services purchased by SNFs. Each year, the update may include an adjustment to account for the MB forecast error for previous years. Since FY2008, when the difference between the estimated MB update and the actual increase is greater than 0.5 percentage point, payments to SNFs are updated to account for this forecast error. When the difference is less than 0.5 percentage point, no adjustments are made. Starting in FY2012, all SNF MB updates will be subject to the productivity adjustment.	For **FY2012**, SNFs received a MB increase of 2.7%, adjusted by a negative 1 percentage point productivity adjustment, and a case-mix adjustment of -12.8%, for a total net decrease of 11.1%. According to the FY2010 CMS Final SNF rule, the **SNF RUG**-III methodology was to be replaced with a revised RUG-IV methodology. And, the Minimum Data Set (MDS) 2.0 patient assessment tool, used to calculate RUG categories, among other things, is replaced with the MDS 3.0 system on October 1, 2010. Due to unexpected utilization patterns with the implementation of the MDS 3.0 system, CMS applied a case-mix adjustment of -12.8% for FY2012. The case-mix adjustment recalibrates therapy RUGs to achieve parity in reimbursement rates between the prior RUG-III methodology and the current RUG-IV methodology. For **FY2013**, SNFs receive a MB increase of 2.5%, reduced by a productivity adjustment of 0.7 percentage points, for a total net increase of 1.8%.

Table 5. Hospice Care

Provider/Service	General payment policy	General update policy	Recent update
Hospice care	Payments for hospice care contain three separate components that are adjusted annually. These components are the payment rates, the hospice wage index, and the cap amount. Limited cost sharing applies to outpatient drugs and respite care. **Payment rates** are based on one of four prospectively determined rates which correspond to four different levels of care (i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care) for each day a beneficiary is under the care of the hospice. The **hospice wage index,** established using the most current hospital wage data available, is used to adjust payment rates to reflect differences in area wages. Total payments to a hospice are subject to an aggregate **cap** that is determined by multiplying the cap amount for a given year by the number of Medicare beneficiaries who received hospice services during the cap year (November 1 to October 31). For purposes of this cap, beneficiaries are counted as fractions should the hospice care overlap across cap years. The fraction is the number of days the beneficiary received hospice services within the cap year as a divided by his or her total days receiving hospice services. Medicare hospice payments that exceed this cap must be returned to the Medicare program. Additionally, the number of inpatient care days is limited to no more than 20% of total patient care days. Days that exceed this limit will be reimbursed under the routine home care rate. Not earlier than October 1, 2013, ACA requires the Secretary to implement budget neutral revisions to the methodology for determining reimbursement for hospice care.	Each of the three components are updated annually. The prospective **payment rates** are updated by the increase in the hospice market basket (MB). Since FY2003 updates have been at the full hospital MB percentage increase. However, for FY2013, the **MB update** will be reduced by 0.3% and adjusted by the productivity factor. For FY2014 – FY2019, a 0.3% reduction to the MB will be contingent upon the level of the insured population relative to the projection of the insured population for 2009. Only if the level of the non-elderly insured population is 5 or fewer percentage point above the projections will the MB be reduced by 0.3%. The **hospice wage index** is updated to reflect updates in the hospital wage index and any changes to the definition of Metropolitan Statistical Areas (MSAs). In 1997, a hospice wage index **budget neutrality adjustment factor (BNAF)** was instituted to account for differences in hospice payments as a result of a change in the data source used to adjust for geographic differences in labor from the 1983 Bureau of Labor Statistics data to the hospital wage index. The final rule for FY2010 phases-out the BNAF over 7 years. As a result, the BNAF was reduced by 10 percent in FY2010, and will be reduced by an additional 15 percent each year from FY2011 through FY2016. The hospice **cap** amount is increased or decreased annually by the same percentage as the medical care expenditure category of the CPI-U.	For **FY2012,** the hospice MB update increased payment rates by 3%. The FY2012 payment rates were: routine home care—$151.03 per day; continuous home care—$881.46 for 24 hours or $36.73 per hour; inpatient respite care—$156.22 per day; and general inpatient care—$671.84 per day. The BNAF reduction of 15% in FY2012 reduced wage index values, lowering aggregate hospice payments by 0.5% in FY2012. For **FY2013**, the hospice MB update is 2.6%. The MB update is reduced by the statutorily required 0.3 percentage points and a productivity adjustment of 0.7 percentage points. The net MB update increases payment rates by 1.6%. The FY2013 payment rates are as follows: routine home care—$153.45 per day; continuous home care—$895.56 for 24 hours or $37.31 per hour; inpatient respite care—$158.72 per day; and general inpatient care—$682.59 per day. The BNAF reduction of 15% reduces wage index values, lowering aggregate hospice payments by 0.7% in FY2013. The latest hospice **cap** amount for the cap year November 1, 2011, through October 31, 2012, is an aggregated $25,377.01 per beneficiary. For the year ending on October 31, 2011, it was an aggregated $24,527.69 per beneficiary.

Part B

Table 6. Physicians

Provider/service	General payment policy	General update policy	Recent update
Physicians	Payments for physicians services are made on the basis of a fee schedule. The fee schedule assigns relative values to services. These relative values reflect differences in the physician work (based on time, skill, and intensity involved), practice expenses (including the cost of nurses and other staff), and malpractice expenses required to produce the service. The relative values are adjusted for geographic variations in the costs of the inputs required to provide physician services. These geographically adjusted relative values are converted into a dollar payment amount by a conversion factor. Assistants-at-surgery services (provided by physicians) are paid 16% of the fee schedule amount. Anesthesia services are paid under a separate fee schedule (based on base and time units) with a separate conversion factor. Medicare payments for most professional services equal 80% of the fee schedule amount; patients are responsible for the remaining 20% coinsurance payment.	The conversion factor is updated each year by a formula specified in law. The update percentage equals the Medicare Economic Index (MEI, which measures inflation) subject to an adjustment to match spending under the cumulative sustainable growth rate (SGR) system. (The SGR is linked, in part, to changes in the gross domestic product per capita.) The adjustment sets the conversion factor so that projected spending for the year will equal allowed spending by the end of the year. Application of the SGR system led to a 5.4% reduction in the conversion factor in 2002. Additional reductions were slated to take effect in subsequent years. However, P.L. 108-7 allowed for revisions in previous estimates used for the SGR calculation, thereby permitting an update of 1.6% effective March 1, 2003. MMA provided that the update to the conversion factor for 2004 and 2005 could not be less than 1.5%. DRA froze the 2006 rate at the 2005 level, TRHCA froze the 2007 rate at the 2006 level; and MMSEA provided that the level for the first six months of 2008 was increased by 0.5%. MIPPA extended this 0.5% increase through the end of 2008 and provided for a 1.1% increase in 2009. For January 1 through May 31, 2010, the update to the conversion factor was set to 0% as a result of three separate acts. For the 18 months from June 1, 2010 through December 31, 2011, the update to the conversion factor was 2.2% as a result of three additional acts. Under current law, the conversion factor update can not be more than three percentage points above nor more than seven percentage points below the MEI,	The TPTCCA and the MCTRJCA extended the SGR override through Dec. 31, 2012, maintaining Medicare physician fee schedule payments at the current level (i.e., payments are frozen). For many years, prior to the passage of MIPPA, beneficiary payments for outpatient mental health services equaled 50% of the fee schedule amounts. MIPPA included a mental health parity provision to be phased in over 5 years. For services provided during calendar year 2011, beneficiaries paid 45% of the covered charges (after meeting their deductible); beginning Jan. 1, 2014, outpatient mental health services will be covered at the same rate (80%) as other Part B services. A 5% add-on payment for certain Medicare mental health services was paid through February, 2012, but was not extended.

Provider/service	General payment policy	General update policy	Recent update
		however, each of the bills that have averted the SGR reductions since DRA have included language that has overridden this condition. ACA included several modifications to Medicare physician reimbursement, including bonus payments for primary care services and for successfully reporting quality measures as well as many adjustments to the methodologies for calculating payments. (See CRS report on Medicare and ACA for details).	

Table 7. Nonphysician Practitioners

Provider/service	General payment policy	General update policy	Recent update
(a) Physician Assistants	Separate payments are made for physician assistant (PA) services, when provided under the supervision of a physician, but only if no facility or other provider charge is paid. Payment is made to the employer (such as a physician). The PA may be in an independent contractor relationship with the employer. The recognized payment amount equals 85% of the physician fee schedule amount (or, for assistant-at-surgery services, 85% of the amount that would be paid to a physician serving as an assistant-at-surgery). Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory for PA services.	See physician fee schedule.	See physician fee schedule. In a skilled nursing facility (SNF), Medicare law allows physicians, as well as nurse practitioners and clinical nurse specialists who do not have a direct or indirect employment relationship with a SNF, but who are working in collaboration with a physician, to certify the need for post-hospital extended care services for purposes of Medicare payment. ACA includes a provision that allows a physician assistant who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes, beginning on or after January 1, 2011.
(b) Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)	Separate payments are made for NP or CNS services, provided in collaboration with a physician, but only if no other facility or other provider charge is paid. The recognized payment amount equals 85% of the physician fee schedule amount (or, for assistant-at-surgery services, 85% of the amount that would be paid to a physician serving as an assistant-at-surgery). Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory.	See physician fee schedule.	See physician fee schedule.
(c) Nurse midwives	The recognized payment amount for certified nurse midwife services equals 65% of the physician fee schedule amount. Nurse midwives can be paid directly. Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory.	See physician fee schedule.	See physician fee schedule.
(d) Certified Registered Nurse Anesthetists (CRNAs)	CRNAs are paid under the same fee schedule used for anesthesiologists. Payments furnished by an anesthesia care team composed of an anesthesiologist and a CRNA are capped at	See physician fee schedule.	See physician fee schedule.

Provider/service	General payment policy	General update policy	Recent update
	100% of the amount that would be paid if the anesthesiologist was practicing alone. The payments are evenly split between each practitioner. CRNAs can be paid directly. Assignment is mandatory for services provided by CRNAs. Regular Part B cost sharing applies.		
(e) Clinical Psychologists and Clinical Social Workers	The recognized payment amount for services provided by a clinical social worker is equal to 75% of the physician fee schedule amount. Services in connection with the treatment of mental, psychoneurotic, and personality disorders of a patient who is not a hospital inpatient are subject to the mental health services limitation. In these cases Medicare pays 50% of incurred expenses and the patient is liable for the remaining 50%. Otherwise, regular Part B cost sharing applies. Assignment is mandatory for services provided by clinical psychologists and clinical social workers.	See physician fee schedule.	See physician fee schedule.
(f) Outpatient physical or occupational therapy services	Payments are made under the physician fee schedule. Medicare coverage for outpatient therapy services, including physical therapy, speech-language pathology services, and occupational therapy have limits or "caps." To accommodate patients with therapy needs that exceed the cap, Congress created an exceptions process that allows for specific diagnoses and procedures to receive Medicare coverage even after a beneficiary has met the therapy cap for the year. In 1999, an annual $1,500 per beneficiary limit applied to all outpatient physical therapy services (including speech-language pathology services), except for those furnished by a hospital outpatient department. A separate $1,500 limit applied to all outpatient occupational therapy services except for those furnished by hospital outpatient departments.	Updates in fee schedule payments are dependent on the update applicable under the physician fee schedule. The $1,500 limits were to be increased by the increase in the MEI beginning in 2002; however, application of the limits was suspended until September 1, 2003. At that time the limits were $1,590. MMA suspended the application of the limits beginning December 8, 2003-December 31, 2005. The limits were restored January 1, 2006. DRA required the Secretary to establish an exceptions process for 2006 for certain medically necessary services. TRHCA extended the exceptions process through 2007; MMSEA extended the process an additional six months. MIPPA extended the exceptions process through December 31, 2009. P.L. 111-309 extended the exceptions process through December 31, 2011, and the TPTCCA and the MCTRJCA extended the exceptions process through Dec. 2012. The limits have increased	See physician fee schedule. The MCTRJCA (Section 3005) extended the exceptions process through December 2012 and created several additional requirements, including the modification that therapy services provided in a hospital outpatient setting be included in the limit. An annual threshold of $3,700 is to be applied separately (1) for physical therapy services and speech-language pathology services, and (2) for occupational therapy services.

Provider/service	General payment policy	General update policy	Recent update
	Therapy services furnished as incident to physicians professional services were included in these limits. The $1,500 limits were to apply each year. However, no limits applied from 2000-2005, except for a brief period in 2003. The limits were restored in 2006; however, an exceptions process has applied in each year since the limits were reintroduced in 2006 . Regular Part B cost sharing applies. Assignment is optional for services provided by therapists in independent practice; balance billing limits apply for non-assigned claims. Assignment is mandatory for other therapy services.	each year as a result of these acts and was $1,870 in CY2011.	

Table 8. Clinical Diagnostic Laboratory Services

Provider/service	General payment policy	General update policy	Recent update
Clinical diagnostic laboratory services	Clinical lab services are paid on the basis of area-wide fee schedules. The fee schedule amounts are periodically updated. There is a ceiling on payment amounts equal to 74% of the median of all fee schedules for the test. Assignment is mandatory. No cost sharing is imposed.	Generally, the Secretary is required to adjust payments annually by the percentage change in the CPI, together with such other adjustments as the Secretary deems appropriate. Updates were eliminated for 1998 through 2002. MMA eliminated updates for 2004-2008. The annual clinical laboratory test fee schedule update adjustment for 2009-2013 is the percentage increase or decrease in the CPI-U minus 0.5 percentage points. MIPPA repealed the Medicare Competitive Bidding Demonstration Project for Clinical Laboratory Services. MIPAA clarified the payment for clinical laboratory services in CAHs. Beginning July 1, 2009, clinical diagnostic laboratory services furnished by a CAH are reimbursed as outpatient hospital services at 101% of costs without regard to whether the individual who receives the service is physically present in the CAH, or in a skilled nursing home or a clinic (including a rural health clinic) that is operated by a CAH when the specimen is collected. The fee schedules were updated by 1.1% in **2003**. Per MMA, no update was made until 2009. In **2009**, the update was 4.5% and for **2010**, the update was -1.9%. ACA authorized a two-year demonstration project, beginning on July 1, 2011, to make separate payments to laboratories for complex diagnostic laboratory tests provided to Medicare beneficiaries. ACA also provided a one year extension (that ended July 1, 2011) for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds to be paid on the basis of reasonable cost.	ACA modified provider updates based on the MB or CPI minus full productivity estimates for all Parts A and B providers and suppliers who are subject to a MB or CPI update. (See above for details.) For the clinical laboratory test fee schedule, the modification replaced the scheduled 0.5% payment reduction for CY2011 through CY2013 with a full productivity adjustment for CY2011 and subsequent years. A 1.75 percentage point reduction to the update in CY2011 through CY2015 was established, which may result in a negative update. The update was -1.75% for 2011 and 0.65% for 2012.

Table 9. Preventive Services

Provider/service	General payment policy	General update policy	Recent update
Physician services (some of which may be provided by certified non-physician providers) include: -initial and annual wellness visits. -screenings for: abdominal aortic aneurysm; bone mass; cervical, breast, colorectal,[a] and prostate cancer (digital rectal exam); glaucoma;[b] and depression. (Procedures only. See next row for associated laboratory services.) -vaccines, and their administration, for influenza, pneumococcus, and (high-risk only) Hepatitis B. -training, counseling, or behavioral therapy for diabetes self-management; medical nutrition therapy; tobacco cessation; cardiovascular disease; alcohol misuse; obesity; and prevention of sexually transmitted infections	Payment is made under the physician fee schedule. In general, no cost sharing is imposed for Medicare preventive services. Exceptions are discussed in table notes. Details of eligibility requirements and coverage for 2012 are at CMS, "Medicare Preventive Services, Quick Reference Information," February, 2012, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.	See physician fee schedule.	See physician fee schedule.

Provider/service	General payment policy	General update policy	Recent update
(STIs) (all high risk only).			
Clinical laboratory services include: -screenings for cervical, prostate (prostate specific antigen test), and colorectal cancer (fecal occult blood only); cardiovascular disease and diabetes (blood tests only); HIV and STIs (both high-risk only).	Payment is based on the clinical diagnostic laboratory fee schedule. In general, no cost sharing is imposed for clinical laboratory services. Details of eligibility requirements and coverage for 2012 are at CMS, "Medicare Preventive Services, Quick Reference Information," February, 2012, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.	See clinical laboratory fee schedule.	See clinical laboratory fee schedule.

a. Deductible, but not coinsurance, is waived for screening colonoscopy procedures in which an abnormality is found (i.e., the screening becomes a diagnostic procedure).

b. Cost sharing for preventive services (both deductable and coinsurance) is waived if a covered service is recommended for routine use (i.e., with a grade of A or B) by the U.S. Preventive Services Task Force (USPSTF), or, for a covered services not so recommended, if one of both forms of cost sharing are explicitly waived in statute. Also, cost sharing is waived for clinical preventive services. Covered preventive services that are not recommended for routine use by the USPSTF include glaucoma screening (for which both deductable and coinsurance apply); and prostate cancer screening (for which both forms of cost sharing apply for digital rectal exam, and both are waived for prostate specific antigen (PSA) testing because it is a clinical laboratory service). For more information, see U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/; and "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act," 75 *Federal Register* 41726 ff., July 19, 2010.

Table 10. Telehealth

Provider/Service	General payment policy	General update policy	Recent update
Telehealth services	Medicare pays for services furnished via an interactive telecommunications system by a physician or practitioner, notwithstanding the fact that the individual providing the service is not at the same location as the beneficiary. Payment is equal to the amount that would be paid under the physician fee schedule if the service had been furnished without a telecommunications system. A facility fee is paid to the originating site (the site where the beneficiary is when the service is provided).	Current law established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31, 2002 at $20. The facility fee for telehealth services provided on or after January 1 of each subsequent calendar year is the amount for the previous year increased as of the first day of the subsequent year by the percentage increase in the Medicare Economic Index (MEI). MIPPA added certain entities as originating sites eligible for payment of telehealth services. Eligible distant site physicians and practitioners who provide services to beneficiaries located at the expanded list of sites may now be paid for qualifying telehealth services. This expanded list includes hospital-based or critical access hospital-based renal dialysis centers (including satellites); skilled nursing facilities (SNFs); and/or community mental health centers (CMHCs.)	For **CY2012**, the MEI increase is 0.6%. The telehealth originating site payment is 80% of the lesser of the actual charge or $24.24.

Table 11. Durable Medical Equipment (DME)

Provider/service	General payment policy	General update policy	Recent update
Durable Medical Equipment (DME)	Except in designated Competitive Bidding Areas, DME is paid on the basis of a fee schedule. Items are classified into five groups for determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than $150 or which are purchased at least 75% of the times); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, fee schedule rates are established locally and are subject to national limits. The national limits have floors and ceilings. The floor is equal to 85% of the weighted average of all local payment amounts and the ceiling is equal to 100% of the weighted average of all local payment amounts. Assignment is optional. Balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies. MMA required the Secretary to begin a program of competitive acquisition for DME, prosthetics and orthotics in which payments for these items would be based on the bids of winning suppliers. Competitive acquisition was to begin in 10 metropolitan statistical areas (MSAs) in 2007, expanding to 80 MSAs in 2008, and additional areas in 2009. The first round of bids were submitted on September 25, 2007, and the program began on July 1, 2008. However, MIPPA stopped the program, terminated all contracts with suppliers and required the Secretary to rebid the first round in 2009. Expansion of the program was delayed by two years until 2011. ACA expanded the number of areas in round two to 91 and requires the Secretary to expand the program or apply competitive rates to remaining areas by 2016.	In general, fee schedule amounts are updated annually by the CPI-U. Updates were eliminated for 1998-2000; payments were increased by the CPI-U for 2001; and payments were frozen for 2002. MMA eliminated the updates for 2004-2008. To pay for the delay in the competitive acquisition program, MIPPA reduced the fee schedule update for 2009 by 9.5% for all items, services and accessories included in round 1 of the competitive bidding program. For 2010 the fee schedule update will be the increase in the CPI-U. Starting in 2011 ACA requires the fee schedule update for DME to be subject to a productivity adjustment, which may result in a negative update.	The update for **CY2003** was 1.1%. As required by MMA, there were no updates for **CY2004, CY2005, CY2006, CY2007, and CY2008**. In **CY2009**, the following 10 items were subject to a 9.5% reduction: oxygen supplies and equipment; standard power wheelchairs, scooters and related accessories; complex rehabilitative power wheelchairs and related accessories; mail-order diabetic supplies; enteral nutrients, equipment, and supplies; continuous positive airway pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies; hospital beds and related accessories; negative pressure wound therapy pumps and related supplies and accessories; walkers and related accessories; and support surfaces, including group 2 mattresses and overlays. All items not subject to the 9.5% reduction received a 5.0% update. For the **CY2010** update, the CPI-U for the applicable period was -1.4%, however Medicare set the update at 0.0%. The update for **CY2011** was -0.1% (or a 0.1% reduction). This represented a 1.1% increase in the CPI-U for the applicable period and a negative multifactor productivity adjustment of 1.2%. The update for **CY2012** is a 2.4% increase over the CY2011 amounts. This represented a 3.6% increase in the CPI-U for the applicable period and a negative multifactor productivity adjustment of 1.2%.

Table 12. Prosthetics and Orthotics

Provider/service	General payment policy	General update policy	Recent update
Prosthetics and orthotics	Except in designated competitive bidding areas as described above, prosthetics and orthotics are paid on the basis of a fee schedule. These rates are established regionally and are subject to national limits which have floors and ceilings. The floor is equal to 90% of the weighted average of all regional payment amounts and the ceiling is equal to 120% of the weighted average of all regional payment amounts. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies.	Fee schedule amounts are updated annually by the CPI-U. MMA eliminated the updates for 2004-2006. Starting in 2011 ACA requires the fee schedule update for prosthetics and orthotics to be subject to a productivity adjustment, which may result in negative update.	The update for **CY2003** was 1.1%. As required by MMA, there were no updates for **CY2004, CY2005** and **CY2006.** The update for **CY2007** was 4.3%. The update for **CY2008** was 2.7%. The update for **CY2009** was 5.0%. For the **CY2010** update, the CPI-U for the applicable period was -1.4%, however Medicare set the update at 0.0%. The update for **CY2011** was -0.1% (or a 0.1% reduction). This represented a 1.1% increase in the CPI-U for the applicable period and a negative multifactor productivity adjustment of 1.2%. The update for **CY2012** is a 2.4% increase over the CY2011 amounts. This represented a 3.6% increase in the CPI-U for the applicable period and a negative multifactor productivity adjustment of 1.2%.

Table 13. Surgical Dressings

Provider/service	General payment policy	General update policy	Recent update
Surgical Dressings	Surgical dressings are paid on the basis of a fee schedule. Payment levels are computed using the same methodology as the durable medical equipment fee schedule (see above). Assignment is optional; balance billing limits do not apply to non-assigned claims. Regular Part B cost sharing applies.	See durable medical equipment fee schedule. Starting in 2011 ACA requires the fee schedule update for medical supplies to be subject to a productivity adjustment, which may result in negative update.	The update for **CY2003** was 1.1%. There was no update for **CY2004**, **CY2005, CY2006, CY2007**, and **CY2008**. The update for **CY2009** was 5.0%. For the **CY2010** update, the CPI-U for the applicable period was -1.4%, however Medicare set the update at 0.0%. The update for **CY2011** was -0.1% (or a 0.1% reduction). This represented a 1.1% increase in the CPI-U for the period and a negative multifactor productivity adjustment of 1.2%. The update for **CY2012** is a 2.4% increase over the CY2011 amounts. This represented a 3.6% increase in the CPI-U for the applicable period and a negative multifactor productivity adjustment of 1.2%.

Table 14. Parenteral and Enteral Nutrition (PEN)

Provider/service	General payment policy	General update policy	Recent update
Parenteral and Enteral Nutrition (PEN)	Except in designated competitive bidding areas as described above, parenteral and enteral nutrients, equipment, and supplies are paid on the basis of the PEN fee schedule. Prior to 2002, PEN was paid on a reasonable charge basis (see below under Miscellaneous Items and Services). The fee schedule amounts are based on payment amounts made on a national basis to PEN suppliers under the reasonable charge system. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost sharing applies.	Fee schedule amounts are updated annually by the CPI-U. MIPPA reduced the fee schedule update for 2009 by 9.5% for all items, services and accessories included in round 1 of the competitive bidding program. Enteral nutrition was included in the first round of competitive bidding, and is thus subject to the 9.5% fee schedule reduction in CY2009. Parenteral nutrition was not included in round 1. Starting in 2011 ACA requires the fee schedule update for parenteral and enteral nutrition to be subject to a productivity adjustment, which may result in a negative update.	In **CY2009** Enteral nutrients, equipment and supplies were subject to the 9.5% reduction while parenteral nutrients received a 5.0% update. For the **CY2010** update, the CPI-U for the applicable period was -1.4%, however Medicare set the update at 0.0%. The update for **CY2011** was -0.1% (or a 0.1% reduction). This represented a 1.1% increase in the CPI-U for the applicable period and a negative multifactor productivity adjustment of 1.2%. The update for **CY2012** is a 2.4% increase over the CY2011 amounts. This represented a 3.6% increase in the CPI-U for the applicable period and a negative multifactor productivity adjustment of 1.2%.

Table 15. Ambulatory Surgical Centers (ASCs)

Provider/service	General Payment policy	General update policy	Recent update
Ambulatory Surgical Centers (ASCs)	Starting January 1, 2008, Medicare will pay for surgery-related facility services provided in an ASC using a payment system based on the hospital outpatient prospective payment system (OPPS). The new payment system will be implemented over a four-year transition period. The ASC payment system uses the same payment groups (APCs) as the OPPS. Many of the ASC relative weights procedures will be the same as in OPPS. Certain services will be eligible for separate payments. The relative weights will be multiplied by a conversion factor (average payment amount) to get a payment for a specific procedure. The ASC conversion factor is based on a percentage of the OPPS conversion factor set to ensure budget neutrality between the old ASC payment system and the new one. CMS uses different methods to set payments for new office-based procedures, separately payable radiology services, separately payable drugs and device intensive services.	MMA eliminated the payment update for FY2005 under the prior payment system, changed the update cycle to a calendar year from a fiscal year, and eliminated the updates for calendar years 2006-2009. MMA also established that a revised payment system for surgical services furnished in an ASC will be implemented on or after January 1, 2006, and not later than January 1, 2008. Total payments under the new system were established as equal to the total projected payments under the old system. As established by the TRHCA, starting in CY2009, the annual increase for ASCs that do not submit required quality data may be the required update minus 2 percentage points. The reduction for not submitting quality data would apply for the applicable year only, and not for subsequent years. Beginning in CY2010, the ASC conversion factor will be updated annually using the consumer price index for all urban consumers (CPI-U) taken to the midpoint of the year involved. The ASC update will include a productivity adjustment starting January 1, 2011.	The **CY2011** update of 1.5% was subject to a multifactor productivity adjustment of 1.3 percentage points and a wage index budget neutrality factor of 0.9996. The CY2011 ASC conversion factor was established at $41.923. The **CY2012** update of 2.7% is subject to a multifactor productivity adjustment of 1.1 percentage points and a wage index budget neutrality factor of 1.0004. The CY2012 ASC conversion factor is established at $42.627.

Table 16. Hospital Outpatient Services

Provider/service	General payment policy	General update policy	Recent update
Hospital Outpatient Departments (HOPDs)	Under HOPD-PPS, which was implemented in August 2000, the unit of payment is the individual service or procedure as assigned to one of about 570 ambulatory payment classifications (APCs). To the extent possible, integral services and items are bundled within each APC, specified new technologies are assigned to new technology APCs until clinical and cost data is available to permit assignment into a clinical APC. Medicare's payment for HOPD services is calculated by multiplying the relative weight associated with an APC by a conversion factor. For most APCs, 60% of the conversion factor is geographically adjusted by the IPPS wage index. Except for new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. Certain APCs with significant fluctuations in their relative weights will have the calculated change dampened. The HOPD-PPS also includes budget-neutral pass-through payments for new technology and budget-neutral outlier payments. Cancer and children's hospitals have a permanent hold harmless protection from the HOPD-PPS. Starting January 1, 2012, cancer hospitals will receive additional payments to reflect their higher costs. This cancer hospital adjustment will be recalculated each year and is implemented in a budget neutral basis. HOPDs in rural hospitals with 100 or fewer beds (that are not SCHs) receive at least 85% of the payment it would have received under the prior payment system during CY2012. All SCHs received 85% of the payment difference for covered HOPD services furnished during CY2011. SCHs with no more than 100 beds receive 85% of the payment difference for covered HOPD services furnished during CY2012 Starting for services on January 1, 2006, rural SCHs will receive a 7.1% payment	The conversion factor is updated on a calendar year schedule. These annual updates are based on the hospital IPPS MB. As established by TRHCA, starting in CY2009, the update for hospitals that do not submit required quality data will be the MB minus 2 percentage points. The reduction for not submitting quality data would apply for the applicable year, and would not be taken into account in subsequent years. ACA established a schedule of annual reductions in the update for starting CY2010 through CY2019. The CY2010 update reduction is 0.25 percentage point. The update will include a productivity adjustment starting January 1, 2012. The ACA update reductions may result in a negative update for that year.	For **CY2011**, the MB update was 2.6% which, as directed by ACA, was reduced by 0.25 percentage point to result in an increase of 2.35%. Hospitals that failed to submit the required quality data receive an update of 1.35%. This increase was adjusted by budget-neutrality factors associated with wage index changes and pass through expenses. The final CY2011 conversion factor for hospitals that did submit the required quality data was $68.876 and was $68.530 for those that did not submit the required data. For **CY2012**, the MB update is 3.0% which, as directed by ACA, is reduced by a productivity adjustment of 1.0 percentage point and by a 0.1 percentage point reduction to result in an increase in 1.9%. Hospitals that did not submit required quality data receive a negative 0.1% update. This increase is adjusted by the required budget neutrality factors for wage index changes (1.005), a cancer hospital payment adjustment (0.9978) and pass-through expenses (0.07). The CY2012 conversion factor is $70.016 for hospitals that submit required quality data and $68.616 for hospitals that did not submit this data. (The prior year's update penalty for not submitting quality data is not taken into account in the next year.)

Provider/service	General payment policy	General update policy	Recent update
	increase..		
	Over time, under Medicare's prior payment system, beneficiaries' share of total outpatient payments grew to 50%. HOPD-PPS slowly reduces the beneficiary's copayment for these services. Copayments will be frozen at 20% of the national median charge for the service in 1996, updated to 1999. Over time, as PPS amounts rise, the frozen beneficiary copayments will decline as a share of the total payment until the beneficiary share is 20% of the Medicare fee schedule amount. A beneficiary copayment amount for a procedure is limited to the inpatient deductible amount established for that year. Balance billing is prohibited. MCTRJCA reduced reimbursement on Medicare beneficiaries' bad debt for HOPD services from 70% to 65%, starting in FY2013.		

Table 17. Rural Health Clinics and Federally Qualified Health Center (FQHCs) Services

Provider/service	General payment policy	General update policy	Recent update
Rural Health Clinics (RHCs) and Federally Qualified Health Center (FQHCs) services	RHCs and FQHCs are paid on the basis of an all-inclusive rate for each beneficiary visit for covered services. An interim payment is made to the RHC or FQHC based on estimates of allowable costs and number of visits; a reconciliation is made at the end of the year based on actual costs and visits. Per-visit payment limits are established for all RHCs (other than those in hospitals with fewer than 50 beds) and FHQCs. Assignment is mandatory; no deductible applies for FHQC services MCTRJCA reduced reimbursement on Medicare beneficiaries' bad debt for RCH and FQHC services from 100% to 88% in FY2013, 76% in FY2014, and 65% in FY2015 and subsequent fiscal years.	Payment limits are updated on January 1 of each year by the Medicare economic index (MEI) which measures inflation for certain medical services. ACA provided for the development and implementation of a prospective payment system (PPS) for Medicare FQHCs to be implemented in 2014. The PPS for Medicare payments to FQHCs will eliminate the Medicare FQHC all-inclusive payment rate, upper payment limits, and productivity guidelines currently in effect.	For **CY2011**, the RHC upper payment limit was $77.99, the urban FQHC limit was $126.10, and the rural FQHC limit was $109.14. For **CY2012**, the RHC upper payment limit is $78.54, the urban FQHC limit is $126.98, and the rural FQHC limit was $109.90.

Table 18. Comprehensive Outpatient Rehabilitation Facility (CORF)

Provider/service	General payment policy	General update policy	Recent update
Comprehensive Outpatient Rehabilitation Facility (CORF)	CORFs provide (by or under the supervision of physicians) outpatient diagnostic, therapeutic and restorative services. Payments for services are made on the basis of the physician fee schedule. Therapy services are subject to the therapy limits (described above for physical and occupational therapy providers).	See physician fee schedule and outpatient physical and occupational therapy services.	See physician fee schedule and outpatient physical and occupational therapy services.

Table 19. Part B Drugs and Biologicals Covered Incident to a Physician's Visit

Provider/service	General payment policy	General update policy	Recent update
Medicare covers certain outpatient drugs and biologicals under the Part B program that are authorized by statute, including those that are: (1) covered if they usually are not self-administered and are provided incident to a physician's services; (2) necessary for the effective use of covered DME; (3) certain self-administered oral cancer and anti-nausea drugs (with injectable equivalents); (4) erythropoietin stimulating agents (ESAs) used to treat anemia; (5) immunosuppressive drugs after covered Medicare organ transplants; (6) hemophilia clotting factors; and (7) vaccines for influenza, pneumonia, and hepatitis B. Throughout this table, all references to Part B drugs also include biological products.	Drug products, except for pneumococcal, influenza, and hepatitis B vaccines, those associated with certain renal dialysis services, blood products and (hemophiliac) clotting factors, and radiopharmaceuticals, are paid using a methodology based on drugs' average sales prices (ASP). The ASP methodology is the volume-weighted average of each manufacturer's ASPs reported to CMS for all National Drug Codes (NDCs) assigned to the same payment and billing code, usually from the Healthcare Common Procedure Coding System (HCPCS). Drugs generally have unique NDC codes for each dose (strength) and package size available for a product. Manufacturers' reported ASP excludes nominal price transactions, such as drug sales subject to the Medicaid rebate, the 340B discount program, TRICARE, and the Veterans Health Administration. Drug makers are required to report ASP and sales volume data to CMS. In general, Medicare's Part B drug payments are set at 106% of ASP for multiple and single source drugs. Medicare's payment covers the drug's acquisition cost as well as administrative overhead attributable to procurement, storage, and handling of the drug. In general, health professionals receive separate payments for Part B drug administration, which vary depending on the entity administering the drug (i.e., physicians, hospital outpatient departments, and DME suppliers). Medicare beneficiaries are responsible for regular cost sharing for Part B drugs, except for pneumococcal and influenza virus vaccines. Part B Drugs Competitive Acquisition Program (CAP) Alternative. MMA required the Secretary to establish a CAP program for Medicare Part B	The Secretary updates ASP quarterly. Payments under the ASP methodology may be lowered by the Secretary if the ASP exceeds either the widely available market price or Average Manufacturer Price (AMP) by a specified percentage (5% in 2006 to present, as determined by the Secretary). In cases where ASP exceeds the market price, CMS's Part B drug payment would equal the lesser of the widely available market price or 103% of AMP. The Department of Health and Human Services Office of Inspector General (OIG) is required to monitor and report on Part B drug prices as well as other drug prices regularly. OIG reports have found that ASP exceeded the 5% AMP threshold for some drugs (see Memorandum Report, Comparison of Fourth-Quarter 2011 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for Second Quarter 2012, OEI-03-12-00410). CMS has elected not to lower payment rates for these drugs, because, they argue that these prices are due to temporary price fluctuations, even though the OIG estimated that Medicare expenditures would be substantially lower. CAP payment amounts are updated annually, and may be adjusted more frequently, but not more often than quarterly, for the following situations: (1) introduction of new drugs, (2) expiration of a drug patent or availability of a generic drug, (3) material shortage that results in a significant price increase for the drug, or (4) withdrawal of a drug from the market. CAP vendors' reasonable net acquisition costs are used, in part, to set payment amounts, but are limited by the weighted payment amounts established under SSA Sec. 1847A. In September 2008, CMS "postponed" the 2009	According to CMS, Part B drugs' ASPs continue to be stable. CMS sets Part B drug payment rates quarterly based on ASP data reported by manufacturers approximately six months earlier. CMS updated Part B drug prices, including FY2012 fourth quarter prices September 6, 2012. Prices for the majority (64%) of the top 50 high volume drugs changed less than 2% between the 4th quarter and the 3rd quarter of 2012 (June 30th compared to September 30th, 2012). Overall, high volume Part B drug prices decreased an average of 1.7% for the fourth quarter of 2012. There are a number of factors that affect the overall average decreases in Part B drug prices, such as multiple manufacturers, alternative therapies, new product entrants, recent generic versions entering the market, or market shifts to lower-priced products.

Provider/service	General payment policy	General update policy	Recent update
	drugs which are not paid on a cost or prospective payment system basis. Part B drug payment amounts furnished during the first year for an approved CAP vendor were set through a competitive process based on each bidder's prices. BioScrip was the only bidder under the Part B drug CAP. BioScrip's contract expired September 10, 2008.	CAP contract, because of issues with qualified bidders. New CAP contracts have not been approved since 2009 contract was postponed.	

Table 20. Blood

Provider/service	General payment policy	General update policy	Recent update
Blood	Medicare pays the reasonable cost for pints of blood, starting with the fourth pint, and blood components that are provided to a hospital outpatient as part of other services. (Blood that is received in an IPPS hospital is bundled into the DRG payment.) For IPPS-excluded hospitals, Medicare pays allowable costs for blood. Beneficiary pays for first three pints of blood (for Parts A and B combined) in a year, after which regular Part B cost sharing applies.	There is no specific update for the reimbursement of Part B blood costs. The outpatient facility is paid 100% of its reasonable costs as reported on its cost-reports. See the section on IPPS hospitals for updates for blood included as part of these hospitals.	No specific update.

Table 21. Partial Hospitalization Services Connected to Treatment of Mental Illness

Provider/service	General payment policy	General update policy	Recent update
Partial hospitalization services connected to treatment of mental illness	Medicare provides Part B hospital outpatient care payments for "partial hospitalization" mental health care. The services are covered only if the individual would otherwise require inpatient psychiatric care. Services must be provided under a structured program which is hospital-based or hospital-affiliated and must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care. The program may also be covered when provided in a community mental health center. Payment for professional services is made under the physician fee schedule. Other services are paid under the hospital outpatient prospective payment system. Regular Part B cost sharing applies; balance billing is prohibited.	See physician fee schedule and hospital outpatient services.	See physician fee schedule and hospital outpatient services.

Table 22. Ambulance Services

Provider/service	General payment policy	General update policy	Recent update
Ambulance services	Ambulance services are paid on the basis of a national fee schedule, which is being phased-in. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. The ground ambulance categories are: basic life support (BLS), both emergency and nonemergency; advanced life support Level 1 (ALS1), both emergency and nonemergency; advanced life support Level 2 (ALS2); specialty care transport (SCT); and paramedic ALS intercept (PI). The air ambulance categories are: fixed wing air ambulance (FW) and rotary wing air ambulance (RW). For air ambulance services, the national fee schedule is fully phased-in. For ground ambulance services, payments through 2009 were equal to the greater of the national fee schedule or a blend of the national and regional fee schedule amounts. The portion of the blend based on national rates was 80% for 2007-2009. In 2010 and subsequently, the payments in all areas will be based on the national fee schedule amount. The payment for a service equals a base rate for the level of service plus payment for mileage. Geographic adjustments are made to a portion of the base rate. For ambulance services provided between July 1, 2008 and December 31, 2012, the fee schedule amounts are increased by 2% for services originating in urban areas and by 3% for services originating in rural areas. For the period July 1, 2004 to December 31, 2012, mileage payments are increased by 22.6% for ground ambulance services originating in rural, low population density areas. MIPPA as extended by ACA (and subsequent legislation) specifies that any area designated as rural for the purposes of making	The fee schedule amounts are updated each year by the CPI-U for the 12 month period ending in June. The update is referred to as the ambulance inflation factor (AIF). Under ACA, starting January 1, 2011, the AIF is adjusted by changes in economy wide productivity. Specifically, the AIF is subject to a 10-year moving average of changes in annual economy wide private nonfarm business multifactor productivity.	In **CY2011**, the CPI-U for the applicable period was 1.1% which was subject to a multifactor productivity adjustment of 1.2 percentage points. Medicare set the AIF for CY2011 a -0.1%. In **CY2012**, the CPI-U for the applicable period is 3.6% which is subject to a multifactor productivity adjustment of 1.2 percentage points. Medicare set the AIF for CY2012 at 2.4%

Provider/service	General payment policy	General update policy	Recent update
	payments for air ambulance services on December 31, 2006, will be treated as rural for the purpose of making air ambulance payments during the period July 1, 2008-December 31, 2012. Regular Part B cost sharing applies. Assignment is mandatory.		

Parts A and B

Table 23. Home Health

Provider/service	General payment policy	General update policy	Recent update
Home health services	Home health agencies (HHAs) are paid under a prospective payment system that began in FY2001. Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits, medical supplies, and others. Durable medical equipment is not included in the home health (HH) PPS. The base payment amount is adjusted for: (1) differences in area wages using the hospital wage index; (2) differences in the care needs of patients (case-mix) using "home health resource groups" (HHRGs); (3) outlier visits (for the extraordinarily costly patients); (4) a partial episode for when a beneficiary transfers from one HHA to another during a 60-day episode; (5) budget neutrality; and (6) a low utilization payment adjustment (LUPA) for beneficiaries who receive four or fewer visits. The HHRG applicable to a beneficiary is determined following an assessment of the patient's condition and care needs using the Outcome and Assessment Information Set (OASIS). After the assessment, a beneficiary is categorized in one of 153 HHRGs that reflect the beneficiary's clinical severity, functional status, and service requirements. Starting in CY2010, outlier payments are capped at 10% of total payments per HHA, and no more than 2.5% of total aggregate PPS payments for all Medicare HH payments. HHAs are paid 60% of the case-mix and wage-adjusted payment after submitting a request for anticipated payment (RAP). The RAP may be	The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the HH market basket (MB) index. This index measures changes in the costs of goods and services purchased by HHAs. DRA specified that HHAs that submit health care quality data, as specified by the Secretary, receive a full MB increase; while HHAs that do not submit such data receive an update equivalent to the MB minus 2 percentage points. This requirement was applicable for CY2007 and each subsequent year. In CY2010, HHAs received the full MB update. As specified in ACA, the MB updates will be reduced by 1.0% for all HHAs in CY2011 through CY2013. For CY2014, HHAs will receive the full MB. Starting in CY2015, the MB update will be subject to the productivity factor adjustment. In CY2008, refinements to the Medicare HH PPS included a reduction in the national standardized 60-day episode payment rate to account for changes in case-mix that are not related to home health patients' actual clinical conditions; among other things. This resulted in a downward payment for a 60-day episode of care of 2.75% for CY2008 through CY2010, and 3.79% for CY2011 and CY2012. Starting in CY2014, ACA requires the Secretary to rebase HH payments by an appropriate percentage to, among other things, reflect the number, mix and level of intensity of	For **CY2011**, the HH MB update is 1.1% for HHAs that submit the required quality data and -0.9% for those that do not. This update reflects the HH MB update minus 1 percentage point, per ACA. The **CY2011** base payment amounts for the 60-day episode were adjusted downward by 3.79% as a result of case-mix refinements. For **CY2012**, the HH MB update is 1.4% for HHAs that submit the required quality data and -0.6% for those that do not. This update reflects the home health market basket update minus 1 percentage point, per ACA. The CY2012 base payment amounts for a 60-day episode are adjusted downward by 3.79% as a result of case-mix refinements.

Provider/service	General payment policy	General update policy	Recent update
	submitted at the beginning of a beneficiary's care once the HHA has received verbal orders from the beneficiary's physician and the assessment is completed. The remaining payment is made when the beneficiary's care is completed or the 60-day episode ends. For visits ending on or after **April 1, 2010,** and before **January 1, 2016**, HHAs will receive a 3% increase to the national standardized 60-day episode rate for services provided to beneficiaries in rural areas.	HH services in an episode, and the average cost of providing care. Any adjustments that result must be made before the annual payment updates are applied for that year (see next column regarding MB updates). A four-year phase-in, ending in 2017, will be implemented, in equal increments, each increment may not exceed 3.5% of the HH PPS base payment amount as of March 23, 2010. ACA also requires the Secretary to reduce the standard HHRG amounts such that the aggregate reduction in payments will equal 5% of total PPS payments for a period.	

Table 24. End-Stage Renal Disease Dialysis Services

Provider/service	General payment policy	General update policy	Recent update
End-stage renal disease (ESRD)	ESRD is a condition of permanent kidney failure, that must be treated either with a kidney transplant or by dialysis. Because of the scarcity of available kidneys for transplant, dialysis is the treatment option for most ESRD beneficiaries. Dialysis treatment removes excess fluid and toxins from the patient's blood. Section 153(b)(1)(E) of MIPPA requires the Secretary to phase-in the ESRD prospective payment system (ESRD PPS) on January 1, 2011 to January 1, 2014. The ESRD PPS payment is a single "bundled" payment for Medicare renal dialysis services per treatment. The ESRD PPS broadens the prior payment system's base rate, or "composite rate", to include items and services such as, erythropoiesis stimulating agents (ESAs), diagnostic laboratory tests among other items. The new ESRD PPS does not adjust reimbursement for the provider's facility type (i.e., hospital, home, independent facility). MIPPA allows providers to make a one-time election to be paid under the ESRD PPS prior to 2014 or to receive a blended payment amount of the prior payment system and the ESRD PPS. Payments include adjustments for case mix, wage differences, high cost outliers (including variations in the amount of ESAs), training, and costs in rural, low-volume facilities (with a minimum payment adjustment of 10% for services furnished between January 1, 2011, and January 1, 2014), among others. The wage index, which adjusts payments for national wage differences, includes a minimum value, or "floor", for Medicare ESRD payments. This floor has been gradually reduced since CY2006. MCTRJCA reduced reimbursement on beneficiaries' bad debt for ESRD services from 100% to 88% in FY2013, 76% in FY2014, and	As required by MIPPA, estimated Medicare total dialysis payments for 2011 equaled 98% of payments that would have been made if the ESRD PPS had not been implemented. Section 1881(b)(14)(F) of the SSA, as added by section 153(b) of MIPPA and amended by section 3401(h) of ACA requires that the ESRD PPS base rate and composite rate portion of the blended payment amount be increased by the annual change in the ESRD market basket (MB). The ESRD market basket increase factor is subject to a productivity adjustment, beginning in 2012. The ESRD wage index floor will be reduced by 0.05 percentage point for each calendar year until CY2014. Beginning in January 1, 2012, providers of renal dialysis services and renal dialysis facilities are subject to quality incentive requirements and a reduction of up to 2% if they do not meet these requirements.	For facilities receiving the blended payment amount, the composite rate for **CY2011** increased by 2.5% to $138.53. For purposes of the composite rate portion of the blended payment amount, an add-on of $0.49 was added to the adjusted composite payment to account for ESRD related drugs and biologicals that were separately paid under Part D and are now included in the ESRD PPS. There was a further reduction in the wage index floor from 0.65 to 0.60. Then, after applying a budget neutrality adjustment of 1.056929, the wage index floor under the blended payment was 0.64320 for **CY2011**. Under the ESRD PPS, the base rate was adjusted downward by 1% to allocate ESRD payments to an outlier pool. The base rate was also adjusted downward by2% to ensure aggregate PPS payments equaled 98% of payments under the prior composite payment system. The ESRD PPS base rate effective January 1, 2011 was $229.63. The base rate was wage adjusted, any applicable patient-level adjustments, facility-level adjustments, outlier adjustments, and training add-on payments were applied to determine the payment rate for a dialysis treatment. The wage index floor under the ESRD PPS was reduced from 0.65 to 0.60. For facilities receiving the blended payment amount, the composite rate for **CY2012** is $141.94. The composite rate includes a market basket update of 3.0% reduced by a 0.9% productivity adjustment. Similar to the prior year, the composite rate includes an add-on of $0.49 to account for ESRD related drugs and biologicals that are separately paid under Part D and are now included in the ESRD PPS. Under the blended payment system, the wage index floor is 0. 552. For **CY2012,** the ESRD PPS

Provider/service	General payment policy	General update policy	Recent update
	65% in FY2015 and subsequent fiscal years.		base rate is $234.81, which includes a 0.1% upward budget neutrality adjustment rate, a market basket update of 3.0%, and a 0.9% productivity adjustment. The wage index floor under the ESRD PPS base rate is reduced from 0.60 to 0.55.

Part C

Table 25. Managed Care Organizations

Provider/service	General payment policy	General update policy	Recent update
(a) Medicare advantage contracts	In general, Medicare makes a monthly risk-adjusted payment in advance to Medicare Advantage (MA) plans for each enrolled beneficiary in a payment area. In exchange, the plans agree to provide all Medicare-covered items and services (except hospice) to each enrollee. In general, the actuarial value of basic cost sharing may not exceed the actuarial value of cost sharing under original Medicare. MMA made substantial changes to Medicare Part C. It created the Medicare Advantage (MA) program, (replacing the Medicare+Choice program) and introduced several changes designed to increase plan availability. The MMA introduced regional plans that operate like Preferred Provider Organizations. Additionally, the MMA created the Part D program (discussed below) to provide outpatient prescription drugs through some MA plans, but also through stand-alone Part D plans. In 2006, the Secretary began determining MA plan payments by comparing plan *bids* to a *benchmark*. A plan's bid is its estimated revenue requirement of providing covered Part A and B services to beneficiaries (including cost of services, administration, and profit). A benchmark is the maximum amount CMS will pay a plan for providing these required benefits. If a plan's bid is less than the benchmark, its payment is equal to its bid plus a rebate equal to a percentage of the difference between its bid and the benchmark. (Before 2012, the rebate was equal to 75%; starting in 2012, the size of the rebate is contingent of plan quality, as explained below.) The remaining amount is	The MA payments are determined annually by the method described under "General Payment Policy." For CY2004 through CY2009, plan benchmarks were updated annually by the minimum percentage increase, or in certain years, 100% of FFS spending in the area (the rebased amount). The minimum percentage increase was the prior year's benchmark increased by the national MA growth percentage (*projected increase in Medicare per capita expenditures*). In years when the Secretary rebased rates, the benchmark for each county was updated by the greater of either the national MA growth percentage, or 100% of FFS spending adjusted to exclude the value of direct medical education payments, as explained below. Beginning in 2004 and at a minimum every third year, the Secretary is required to rebase FFS payment rates. Rebasing is updating FFS rates to reflect recent growth in health care expenditures. The update to the benchmark for regional plans has both a statutory increase and a competitive increase. The statutory component is similar to the update for other MA plans and the competitive component is based on a weighted average of plan bids. DRA made additional changes to the benchmark calculation. Beginning in 2007, DRA added two new adjustments to calculating the benchmark: (1) an adjustment to exclude budget neutrality in risk adjustment, and (2) an adjustment to account for coding intensity differences between MA plans and original Medicare for years 2007 through 2010. The	For **CY2010**, MA benchmarks were not rebased. All benchmarks were updated by the increase in the national MA growth percentage (0.81%), adjusted for budget neutrality (1.001), and the phase-out of IME (a maximum reduction of approximately 0.6%). Also for CY2010, a uniform 3.4% reduction was applied to the risk scores of all MA plan enrollees to account for differences in coding patterns between MA plans and providers under Parts A and B of original Medicare. As required by ACA, the benchmarks for **CY2011** were the same as those in CY2010. In **CY2012**, MA benchmarks begin the phase-in to rates based on a percent of FFS spending in each county. For the portion of the benchmark based on the pre-ACA methodology, the benchmarks were rebased. This means that that part of the county benchmarks are set at the greater of the new estimate of FFS spending in the county, or the previous year's benchmark increased by the national MA growth percentage (-0.16%), and adjusted to phase-out IME. For the portion of the benchmark based on the ACA methodology, the base amount was set at the rebased FFS estimate for each county, adjusted to phase-out IME. Additional adjustments include: (a) an adjustment to reflect the amount of additional payments that would have been made if beneficiaries had not received services from facilities of the Department of Defense, and the Department of Veterans Affairs, (b) a uniform 3.41% reduction applied to plan risk scores to

Provider/service	General payment policy	General update policy	Recent update
	retained by the federal government. If a plan's bid is greater than the benchmark, its payment is equal to the benchmark and the plan must make up the difference between its bid and the benchmark by charging a beneficiary premium. In general, the Secretary has the authority to review and negotiate plan bid amounts to ensure that the bid reflects revenue requirements. At least one plan offered by an MA organization must be an MA-PD plan, one that offers Part D prescription drug coverage. MA organizations offering prescription drug coverage receive a direct subsidy for each enrollee in their MA-PD plan, equal to the plan's risk adjusted standardized bid amount (reduced by the base beneficiary premium). The plans also receive a reinsurance payment amount for the federal share of their payment as well as premium and cost-sharing reimbursements for qualified low-income enrollees. Also beginning in 2006, the MA program began offering regional plans covering both in- and out-of-network required Medicare services. To encourage regional plan participation in the program additional payments were authorized in certain circumstances for hospitals that would not otherwise join a private plan's network. Beginning in 2012, for MA plans that bid below the benchmark, the rebate will be contingent on plan quality as measured by a 5-star quality rating system established by the Secretary. The calculation will be phased in over three years from 75% for all MA plans that bid below the benchmark for years prior to 2012, to a rate of 70% for plans with a star rating of 4.5 or higher, 65% for plans with a star rating of 3.5 or greater, but below 4.5 stars, and 50% for plans with less than 3.5 stars. The rebate based on plan quality will be fully phased-in by 2014.	adjustment to exclude budget neutrality in the risk adjustment was completed in 2010. DRA required the Secretary to conduct a study of the difference between treatment and coding patterns between MA plans and providers under Parts A and B of Medicare. The findings were to be incorporated into calculations of MA benchmarks in 2008, 2009, and 2010, however they were first incorporated in 2010. Beginning in 2010, MIPPA requires that the value of indirect medical education (IME) be phased-out of all benchmarks. The amount phased-out each year is based on a ratio of (1) a specified percentage (0.60% in the first year), relative to (2) the proportion of per capita costs in original Medicare in the county that IME costs represent. The effect of the ratio is to phase-out a higher proportion of IME costs in areas where IME makes up a smaller percentage of per capita spending in original Medicare. After 2010, the numerator of the phase-out percentage is increased by 0.60 percentage points each year. CY2011 benchmarks were frozen at the CY2010 level. Starting in CY2012, a new benchmark calculation based on a percentage of fee-for-service spending in each county began to be phased-in. In CY2012, for the portion of the benchmark based on the new methodology, the "base rate" equals 100% FFS spending in the area and is updated each year by either the increase in the national MA growth percentage, or rebased FFS amounts. County benchmarks are set at either 95%, 100%, 107.5% or 115% of the base rate, with higher percentages applied to counties with the lowest FFS spending. In other words, the 25% of all counties with the lowest FFS spending have their base rate adjusted by 115%, while the 25% of counties with the highest FFS spending have their base	account for differences in coding patterns between MA plans and providers under Parts A and B of original Medicare, and (c) quality bonus payment demonstration. For CY2012 and CY2013, the quality bonus demonstration increases to the benchmarks are 5% for 5-star plans, 4% for 4-star and 4.5-star plans, 3.5% for 3.5-star plans, and 3% for 3-star plans.

Provider/service	General payment policy	General update policy	Recent update
		rate adjusted by 95%. The phase-in will take place over 2 to 6 years, with a larger phase-in period for areas where the new methodology would result in larger benchmark decreases. Under the ACA, starting in CY2012, benchmarks are increased based on plan quality with higher increases in qualifying areas. However, for CY2012 through CY2014, the Secretary is implementing a quality bonus demonstration program which increases the size of the quality bonus adjustments specified in the ACA, expands the number of eligible plans, and changes how the adjustment applies to the benchmark. Also, under the demonstration, the bonuses may result in benchmarks that are higher than the pre-ACA benchmarks. The coding intensity adjustment first specified in DRA continues after CY2010 with specified minimum adjustments starting in CY2014.	

Provider/service	General payment policy	General update policy	Recent update
(b) Cost contracts	Medicare pays cost contract health maintenance organizations (HMOs) and competitive medical plans (CMPs) the actual costs they incur for furnishing Medicare-covered services (less the estimated value of required Medicare cost sharing), subject to a test of "reasonableness." Interim payment is made to the HMO/CMP on a monthly per capita basis; final payment reconciles interim payments to actual costs. A portion of Medicare beneficiaries' bad debt (beneficiaries' cost sharing obligations that the plan has been unable to collect) are reimbursed by Medicare, with certain restrictions. MCTRJCA reduces reimbursement on bad debt for Cost plans from 70% to 65%, starting in FY2013. Beginning January 1, 2013, cost contracts can not be extended or renewed in a service area if, during the entire previous year, the service area had two or more MA regional plans or two or more MA local plans offered by different organizations.	No specific update. Cost-based HMOs are paid 100% of their actual costs.	No specific update.

Part D

Table 26. Outpatient Prescription Drug Coverage

Provider/service	General payment policy	General update policy	Recent update
Part D drug coverage. Outpatient prescription drug coverage is provided through private prescription drug plans (PDPs) or MA prescription drug (MA-PD) plans. The program relies on these private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies cover the bulk of the risk. Unlike other Medicare services, the benefits can only be obtained through private plans. While all plans have to meet certain minimum requirements, there are significant differences among them in terms of benefit design, beneficiary premiums, drugs included on plan formularies (i.e., list of covered drugs) and cost sharing applicable for	Federal payments to plans are linked to "standard coverage." Qualified Part D plans are required to offer either "standard coverage" or alternative coverage, with at least actuarially equivalent benefits. For 2012, most plans offer actuarially equivalent benefits or enhanced coverage rather than the standard package. A number of plans have reduced or eliminated the deductible. Many plans offer tiered cost sharing under which lower cost sharing applies for generic drugs, higher cost sharing applies for preferred brand name drugs, and even higher cost sharing applies for non-preferred brand name drugs.	The definition of standard coverage is updated annually based on the estimated increase in per capita costs for the 12 month period ending the previous July. ACA, phases out the Part D doughnut hole. Beginning in 2011, manufacturers are required to provide a 50% discount on brand-name drugs during the coverage gap to participate in the Part D program. The law phases in Medicare coverage for generic drugs during the coverage gap starting in 2011, and for brand name drugs in 2013. When the doughnut hole is fully phased out in 2020, Part D enrollees will be responsible for 25% of the cost of brand name and generic drugs during the coverage gap (the same as in the initial coverage phase). The catastrophic coverage limit will also be reduced to a small extent in years 2014 through 2019.	In **CY2012**, "standard coverage" has a $320 deductible and 25% coinsurance for costs between $320 and $2,930 (the initial coverage period). From this point, there is limited coverage, until the beneficiary has total out-of-pocket costs of $4,700 (about $6,657.50 in total spending)[a]; this coverage gap has been labeled the "doughnut hole." In 2012, non-LIS enrollees receive a 50% discount off of brand name drugs and a 14% Medicare subsidy for the cost of their generic drugs purchased during the coverage gap period. Once the beneficiary reaches the catastrophic limit, the program pays all costs except for nominal cost sharing.

Provider/service	General payment policy	General update policy	Recent update
particular drugs. Drug prices under Part D are determined through negotiations between the PDPs, or MA-PDs, and drug manufacturers. The Secretary of Health and Human Services is statutorily prohibited from intervening in Part D drug price negotiations. Certain individuals with incomes below 150% of poverty may qualify for the low-income subsidy (LIS) which covers most or all of their premiums, cost sharing, and drug costs during the coverage gap.			
Federal Subsidy Payments	Federal subsidy payments (including both direct payments and reinsurance payments) are made to plans consistent with an overall subsidy level of 74.5% for basic coverage. Direct monthly per capita payments are made to a plan equal to the plan's standardized bid amount adjusted for health status and risk and reduced by the base beneficiary premium, as adjusted to reflect the difference between the bid and the national average bid. Reinsurance payments, equal to 80% of allowable costs, are provided for enrollees whose costs exceed the annual out-of-pocket threshold ($4,700 in 2012). Plans that enroll individuals eligible for the low-income subsidy (LIS) receive an additional subsidy to cover most of the premiums and cost sharing and for drug coverage in the coverage gap for	Payments to plans are calculated annually by the method described under "General Payment Policy."	Federal payments were recalculated for the 2012 plan year. The national average monthly bid amount for 2012 is $84.50.

Provider/service	General payment policy	General update policy	Recent update
	these individuals.		
Beneficiary Premiums	Beneficiary premiums represent on average 25.5% of the cost of the basic benefit. A base beneficiary premium is calculated based on the national average monthly bid amount for basic coverage. This amount is then adjusted, up or down as appropriate, to reflect differences between the plan's standardized bid amount and the national average monthly bid amount. It is further increased for any supplemental benefits and decreased if the individual is entitled to a low-income subsidy. Additionally, since 2011, Part D enrollees with higher incomes pay higher premiums. The premium is the same for all individuals in a particular plan (except those entitled to a low income subsidy and those subject to high-income premiums).	Beneficiary premiums are calculated annually by the method described under "General Payment Policy."	Beneficiary premiums were recalculated for the 2012 plan year. The base beneficiary premium for 2012 is $31.08. (Actual premiums paid by individual beneficiaries vary from one Part D plan to another.)
Risk corridors	The federal government and plans share the risk for costs within specified "risk corridors." "Risk corridors" are specified percentages for costs above and below a target amount; the target amount is defined as total payments paid to the plan taking into account the amount paid to the plan by the government and enrollees.	In 2006 and 2007, plans were at full risk for costs within 2.5% above or below the target. If costs were between 2.5% and 5% above the target, they were at risk for 25% of spending between 2.5% and 5% of the target and 20% of spending above that amount. If plans fell below the target, they have to refund 75% of the savings if costs fall between 2.5% and 5% below the target and 80% of any amounts below 5% of the target. For 2008-2011, risk corridors are modified. Plans are at full risk for spending within 5% above or below the target. They are at risk for 50% of spending between 5% and 10% of the target and 20% of any spending exceeding 10% of the target.	The 2012 risk corridors are unchanged from contract year 2011.

a. The actual amount of total spending will depend on the mix of brand name and generic drugs used by the beneficiary during the coverage gap.

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