
Medicare's Quagmire

Medicare covers nearly 44 million beneficiaries, including 37 million seniors and 7 million younger adults with permanent disabilities and end-stage renal disease. The program cost the federal government approximately \$375 billion in 2006, accounting for 13% of federal spending, according to a panel of experts during a recent presentation by the Alliance for Health Reform and the Kaiser Family Foundation (see: www.allhealth.org/briefing_detail.asp?bi=102). Medicare, along with Medicaid and private payers, is moving toward value-based purchasing to be sure that beneficiaries are getting quality care, and providing incentives to providers to improve the quality of care. The movement is painful for providers and the Federal budget alike.

During the recent Alliance for Health Reform presentation, Tom Ault of Health Policy Alternatives, discussed how Medicare coverage decisions are made and highlighted some of what Medicare providers can expect in the coming years of Medicare reform. Highlights of his presentation are outlined here.

According to Ault, Medicare dollars are spent as follows (Figure 1):

- 40% pay for Part A services (inpatient, skilled nursing facilities [SNFs], home health agencies [HHAs])
- 34% are used to reimburse physicians and other outpatient providers through Part B
- 19% of Medicare dollars go to Part C (Medicare Advantage)
- 7% are for Part D (prescription drug benefits)

How Is Coverage Decided?

Ault explained that there are two ways by which Medicare coverage decisions are made: about 10% of decisions are determined on the national level by the Centers for

Medicare and Medicaid Services (CMS); and 90% are developed by local Medicare contractors. Local decision makers include fiscal intermediaries for Part A (hospitals, SNFs, HHAs), carriers for Part B (physician services), and carriers for regional durable medical equipment carriers (DMERCs). Ault noted that a move is underway to combine these fiscal intermediaries and carriers into Medicare Administrative Contractors, or MACs.

In his presentation, Ault detailed the three types of coding used for payment decisions in fee-for-service plans (in which 81% of Medicare beneficiaries fall). Coding depends on the type of services provided (Figure 2). The billing for professional services delivered by physicians and other healthcare professionals is processed by carriers using the American Medical Association's current procedure terminology (CPT) codes. Claims for certified Medicare durable medical equipment (DME) suppliers are processed by regional carriers

(DMERCs) using the Health Care Common Procedure Coding System (HCPCS). Fiscal intermediaries process the claims of hospitals, SNFs, HHAs, and others facilities using the International Classification of Disease Clinical Modification (ICD-9) maintained by CMS and the National Center for Health Statistics.

When Medicare began in 1966, payments were based on reasonable cost and reasonable charges, Ault explained. Most Medicare service payments today are based on a percent-to-pay system or a fee schedule (Table 1). The inpatient hospital prospective payment system (PPS) uses diagnosis-related groups (DRGs). Outpatient PPS plans use ambulatory payment classifications (APCs). SNFs have a per diem PPS. Physicians, DMEs, and clinical laboratories are paid on a fee schedule. HHAs are paid on a PPS by episodes of care. Payments for drugs and biologicals (those given at a physician's office or clinic) are based on the average sales price (ASP).

Physician Fee Schedule

Ault further explained that the payments are calculated based on the relative costs of resources required to provide medical services. Three components are involved:

1. Physician work (about 53% or \$40 billion)
2. Practice expense (about 43% or \$32 billion)
3. Malpractice insurance (about 4%, or \$3 billion)

These three components are as-

signed relative value units (RVUs), said Ault, which are added and multiplied by a dollar conversion factor to calculate the payments made to the physician. Payments are also adjusted according to geographical location, excepting surgical services, which are paid on a global basis.

No Quick or Easy Fixes

It's no news that Medicare physician payments are backed against a wall, explained Ault. The 2006 Trustees Report projects physician updates of -5% for at least 9 years (through 2015). Therefore, by 2015, payment rates will fall by more than 35% compared to 2001. (Negative updates are driven by the sustainable growth rate [SGR], which limits the year-to-year growth in physician volume intensity, and when physicians' services grow faster than this target, the update is reduced.) While the updates are projected to fall 35% over the next 9 years, the cost of providing care, as measured by the Medicare economic index (MEI), is projected to increase 40%, claimed Ault.

Fixing the physician update problem is not easy. According to Ault, even a 10-year rate freeze is expensive: it would cost \$180 billion in federal dollars and increase the federal deficit by the same amount, requiring a \$50-billion increase in beneficiary premiums. Medicare Part B premiums are already rising significantly, from \$50 in 2001 to \$93.50 in 2007. The increase in premiums reflects overall growth in healthcare spending, some of which is attributable to a shift toward outpatient care.

Figure 1. How Medicare Dollars Are Spent

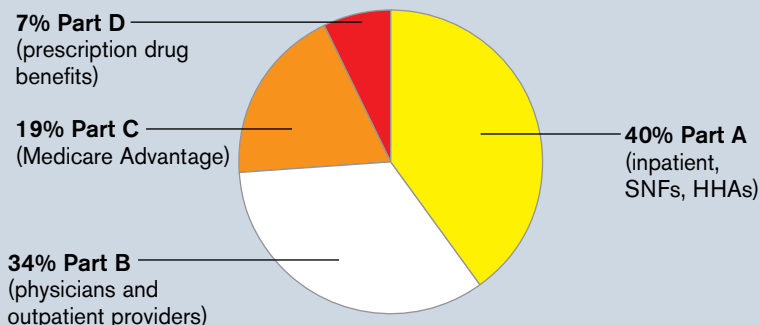


Figure 2. Medicare Fee-For-Service

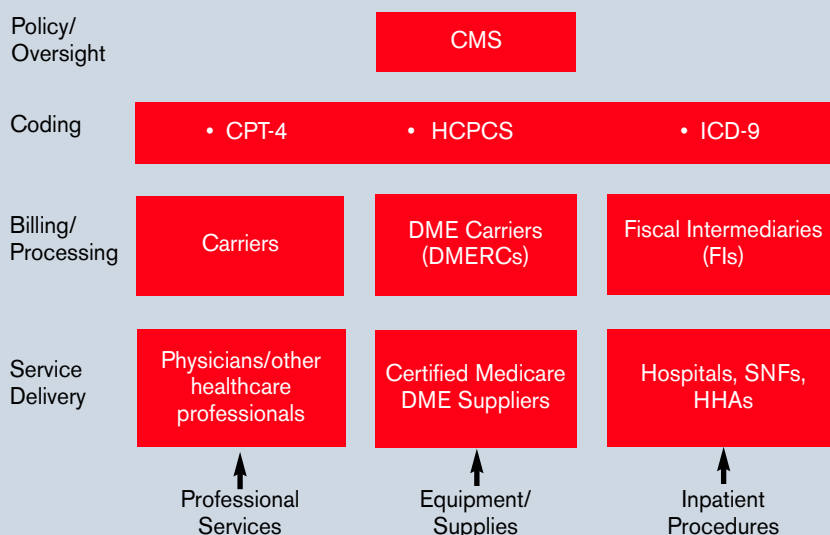


Table 1.

Medicare Payment Systems Vary by Type

Site/Type of Service	Payment Mechanism
Inpatient hospital PPS	Diagnostic-related group (DRG)
Outpatient hospital PPS	Ambulatory payment classification (APC)
Skilled nursing facility PPS	Per diem (case mix adjusted)
Physician	Fee schedule (RBRVS)
Durable medical equipment	Fee schedule (DMEPOS)
Clinical laboratory	Fee schedule
Home health agency	Episodes of care (case mix adjusted)
Covered drugs/biologicals	Average sales price (ASP)

DMEPOS=durable medical equipment prosthetics, orthotics, and supplies; PPS=prospective payment system; RBRVS=resource-based relative value scale

Source: Figures 2 and Table 1 are from Tom Ault's presentation slides and can be found at: www.allhealth.org/briefing_detail.asp?bi=102.

PROVIDER ACTION

Impact to You

Medicare financial constraints promise to get tougher, which will likely result in increasing pressure to lower physician reimbursement.

What You Need to Know

Beware of the potential for further Medicare cuts in reimbursement so your practice is prepared. Sources such as MedPAC (www.MedPAC.gov), which advises Congress on physician reimbursement is an excellent resource for up-to-date information on the projections for physician reimbursement.

What You Need to Do

Physicians need to work on 2 levels to ensure continued success for their practices. On 1 front, working to reduce overhead within your practice will help ensure you are billing appropriately for your services. Your range of services can also be increased or decreased to provide the best opportunity for success within your market. On a second front, become active in your state and national medical associations and on an individual level contact your state representatives to push for appropriate reimbursement for physician services.

Hospital Outpatient Fee Schedule

The hospital outpatient prospective payment system (OPPS) relies on APCs, which are roughly equivalent to a procedure, a clinic or emergency department visit, or an item such as a drug or device, explained Ault. Separate payments are made for each item or service provided during an outpatient visit and coded for payment using CPT or HCPCS. Payments are based on relative median costs of services in an APC compared to relative median costs of all APCs. Rates include packaged items such as anesthesia, supplies, certain drugs, and use of recovery/observation rooms. According to Ault, the impact of this payment system has been a cumulative inflation rate for outpatient services of 14.6% from 2003 to 2006, with rural hospitals at a 21% rate.

Hospital Inpatient Fee System

During his presentation, Ault explained that the inpatient hospital

PPS is an all-inclusive, fixed payment per admission system, determined by DRGs. Hospital payments are bundled and cover all services during the hospital stay except physician or practitioner services. The guiding philosophy behind this payment system, said Ault, is that hospitals should make both clinical and economic decisions.

A DRG is a patient classification system used to categorize different types of inpatients based on severity of illness, taking into account resource demands and costs experienced by the hospital. Ault explained that assignment to DRGs is based on the specific principal diagnosis and includes the cause for admission, the age of the patient, the need for a major surgical procedure, and complications and comorbidities. Relative payment weights are calculated for a DRG based on its average costs relative to those for all DRGs. These weights are recalibrated each year by Medicare.

Advanced Reduction in Hospital Payments

Currently proposed regulation calls for a major change in the DRG system to severity-adjusted DRGs. It also calls for an advanced across-the-board reduction in Medicare's payment of 2.4% per year for 2 years, for a total of -4.8%. The justification for this reduction, according to Ault, is a belief that switching to this new severity-adjusted DRG system will cause "case-mixed creep."

Ault stated that Medicare will be submitting a plan to Congress this year for an actual value-based purchasing program for hospitals in which they'll have to do more than just report—they will also have to achieve certain levels of performance or their payments will be reduced. An incentive program for hospital payments that is based on performance will likely start in 2009, said Ault. Another issue in the inpatient hospital PPS is whether disproportionate-share hospital payments, which make special adjustments for hospitals with greater numbers of low-income patients, are fairly allocated. The argument, said Ault, is that the payments are skewed for large urban hospitals and do not accurately measure the proportion of low-income patients in rural and small urban facilities.

Conclusion

Medicare reform faces a number of difficult issues in balancing budget with quality care. Performance-based payment systems for hospitals and physicians must keep outcomes measures up to date and incentives properly aligned with program goals for improved quality. The success of these measures remains to be seen, Ault concluded. **MPM**