SECTION 2-MEDICARE

(Note: This chapter does not include information or data on the changes to the Medicare Program from Public Law 108-173, signed on December 8, 2003).

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OVERVIEW

Medicare is a nationwide health insurance program for the aged and certain disabled persons. The program consists of two parts–Part A, hospital insurance (HI) and Part B, supplementary medical insurance (SMI). Total program outlays were $256.8 billion in fiscal year 2002. Net outlays, after deduction of beneficiary premiums, were $230.9 billion.

COVERAGE

Almost all persons over age 65 are automatically entitled to Medicare Part A. Part A also provides coverage, after a 24-month waiting period, for persons under age 65 who are receiving Social Security cash benefits on the basis of disability. Most persons who need a kidney transplant or renal dialysis also may be covered, regardless of age. In fiscal year 2003, Part A covered an estimated 40.3 million aged and disabled persons (including those with chronic kidney disease). Medicare Part B is voluntary. All persons over age 65 and all persons enrolled in Part A may enroll in Part B by paying a monthly premium - $58.70 in 2003. In fiscal year 2003, Part B covered an estimated 38.3 million aged and disabled persons.

BENEFITS

Part A provides coverage for inpatient hospital services, up to 100 days of

post hospital skilled nursing facility (SNF) care, some home health services, and hospice care. Patients must pay a deductible ($840 in 2003) each time their hospital admission begins a benefit period. (A benefit period begins when a patient enters a hospital and ends when she has not been in a hospital or SNF for 60 days.) Medicare pays the remaining costs for the first 60 days of hospital care. The limited number of beneficiaries requiring care beyond 60 days are subject to additional charges. Patients requiring SNF care are subject to a daily coinsurance charge for days 21-100 ($105 in 2003). There are no cost-sharing charges for home health care and limited charges for hospice care.

Part B provides coverage for physicians' services, laboratory services, durable medical equipment (DME), hospital outpatient department (OPD) services, and other medical services. The program generally pays 80 percent of Medicare's fee schedule or other approved amount after the beneficiary has met the annual $100 deductible. The beneficiary is liable for the remaining 20 percent.

PAYMENTS FOR SERVICES

Taken together, spending for inpatient hospital and physicians' and related services accounts for close to 75 percent of Medicare fee-for-service payments (spending for managed care plans is not broken down by service category). Medicare makes payments for inpatient hospital services under a prospective payment system (PPS); a predetermined rate is paid for each inpatient stay based on the patient's diagnosis at discharge. Payment for physicians' services is made on the basis of a fee schedule. Specific payment rules are also used for other services.

ADMINISTRATION

Medicare is administered by the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (DHHS). (Prior to June 14, 2001, this agency was known as the Health Care Financing Administration (HCFA).) Much of the day-to-day work of reviewing claims and making payments is done by fiscal intermediaries (for Part A) and carriers (for Part B). These are commercial health insurers or Blue Cross Blue Shield plans.

FINANCING

Medicare Part A is financed primarily through the HI payroll tax levied on current workers and their employers. Employers and employees each pay a tax of 1.45 percent on all earnings. The self-employed pay a single tax of 2.9 percent on earnings.

Part B is financed through a combination of monthly premiums levied on program beneficiaries and Federal general revenues. In 2003, the premium is $58.70. Beneficiary premiums have generally represented about 25 percent of Part B costs; Federal general revenues (i.e., tax dollars) account for the remaining 75 percent.

FEDERAL OUTLAYS

Total program outlays were $256.8 billion in fiscal year 2002. Net outlays (i.e., net of premiums beneficiaries pay for enrollment, largely for Part B) were $230.9 billion. Tables 2-1, 2-2, and 2-3 provide historical spending and coverage data for Medicare.

TABLE 2-1--MEDICARE OUTLAYS, SELECTED FISCAL YEARS 1967-2008

[In Millions of Dollars]

Fiscal Year	Part A	Part B	Total Medicare Outlays	Medicare Premium Offsets	Net Medicare Outlays	Percent Increase (Over Prior Year)
1967	$2,597	$798	$3,395	-$647	$2,748	NA
1970	4,953	2,196	7,149	-936	6,213	9.1
1975	10,612	4,170	14,782	-1,907	12,875	33.6
1980	24,288	10,746	35,034	-2,945	32,089	21.1
1985	48,667	22,730	71,397	-5,562	65,835	14.0
1990	66,687	43,022	109,709	-11,607	98,102	15.5
1991	70,742	47,021	117,763	-12,174	105,589	7.6
1992	81,971	50,285	132,256	-13,232	119,024	12.7
1993	91,604	54,254	145,858	-15,305	130,553	9.7
1994	102,770	59,724	162,494	-17,747	144,747	10.9
1995	114,883	65,213	180,096	-20,241	159,855	10.4
1996	127,683	68,946	196,629	-20,088	176,591	10.5
1997	137,884	72,553	210,437	-20,421	190,016	7.6
1998	137,298	76,272	213,570	-20,747	192,823	1.5
1999	131,500	80,518	212,018	-21,561	190,457	-1.2
2000	130,030	88,992	219,022	-21,907	197,115	3.5
2001	142,901	99,452	242,353	-23,748	218,605	10.9
2002	148,013	108,825	256,838	-25,952	230,886	5.6
2003 est.	152,925	120,019	272,944	-28,269	244,675	6.0
2004 est.	162,358	121,518	283,876	-30,998	252,878	3.4
2005 est.	170,228	128,467	298,695	-32,826	265,869	5.1
2006 est.	174,506	131,909	306,415	-34,522	271,893	2.3
2007 est.	185,245	140,504	325,749	-36,339	289,410	6.4
2008 est.	195,550	149,601	345,151	-38,755	306,396	5.9

Note-Excludes offsetting receipts (except for premiums).

Source: Office of the President, 2003.

ELIGIBILITY AND COVERAGE

AGED

Part A

Most Americans age 65 or older are automatically entitled to protection under Part A. These individuals (or their spouses) established entitlement during their working careers by paying the HI payroll tax on earnings covered by either the Social Security or Railroad Retirement Systems.

The HI tax was extended to Federal employment with respect to wages paid on or after January 1, 1983. Beginning January 1, 1983, Federal employment is included in determining eligibility for protection under Medicare Part A. A transitional provision allows individuals who were in the employ of the Federal Government both before and during January 1, 1983, to have their prior Federal employment considered as employment for purposes of providing Medicare coverage. Employees of State and local governments, hired after March 31, 1986, are also liable for the HI tax.

Persons age 65 or older who are not automatically entitled to Part A may obtain coverage, providing they pay the full actuarial cost. The 2003 monthly premium is $316 ($174 for persons who have at least 30 quarters of covered employment).

Part B

Part B of Medicare is voluntary. All persons age 65 or older (even those not entitled to Part A) may elect to enroll in the SMI Program by paying the monthly premium. The 2003 premium is $58.70 per month. Persons who voluntarily enroll in Part A are required to enroll in Part B.

DISABLED

Part A

Part A also covers, after a 2-year waiting period, people under age 65 who are either receiving monthly Social Security benefits on the basis of disability or receiving payments as disabled Railroad Retirement System annuitants. (Dependents of the disabled are not eligible.) The 24-month waiting period is waived for persons with amyotrophic lateral sclerosis. In addition, most people who need a kidney transplant or renal dialysis because of chronic kidney disease are entitled to benefits under Part A regardless of age.

Part B

Persons eligible for Part A by virtue of disability or chronic kidney disease may also elect to enroll in Part B.

TABLE 2-2--NUMBER OF MEDICARE ENROLLEES BY TYPE OF COVERAGE AND TYPE OF ENTITLEMENT, SELECTED YEARS 1968-2001

[In Thousands]

Type of Entitlement and Coverage	Year								Average Annual Rate of Growth (Percent)		
	1968	1975	1980	1985	1990	1995	2000	2001	1968-1975	1985-1995	1995-2001
All Enrollees											
HI[1] and/or SMI[2]	19,821	24,959	28,478	31,083	34,203	37,535	39,620	40,026	3.3	1.9	1.1
Total HI	19,770	24,640	28,067	30,589	33,719	37,135	39,199	39,607	3.2	2.0	1.1
HI Only	1,016	1,054	1,079	1,094	1,574	1,850	2,260	2,341	0.5	5.4	4.0
Total SMI	18,805	23,905	27,400	29,989	32,629	35,685	37,360	37,685	3.5	1.8	0.9
SMI Only	51	318	411	493	484	400	421	419	29.9	-2.1	0.8
Aged											
HI and/or SMI	19,821	22,790	25,515	28,176	30,948	33,142	34,253	34,462	2.0	1.6	0.7
Total HI	19,770	22,472	25,104	27,683	30,464	32,742	33,833	34,044	1.8	1.7	0.7
HI Only	1,016	845	835	865	1,263	1,000	1,663	1,713	-2.6	1.5	9.4
Total SMI	18,805	21,945	24,680	27,311	29,686	31,742	32,590	32,749	2.2	1.5	0.5
SMI Only	51	318	411	493	484	400	420	418	29.9	-2.1	0.7
All Disabled											
HI and/or SMI	[4]	2,168	2,963	2,907	3,255	4,393	5,367	5,563	NA	4.2	4.0
Total HI	[4]	2,168	2,963	2,907	3,255	4,393	5,367	5,563	NA	4.2	4.0
HI Only	[4]	209	244	229	311	451	597	626	NA	7.0	5.6
Total SMI	[4]	1,959	2,719	2,678	2,943	3,942	4,770	4,937	NA	3.9	3.8
SMI Only [3]	[4]	0	0	0	0	0	0	0	NA	NA	NA
End-Stage Renal Disease Only											
HI and/or SMI	[4]	13	28	31	65	71	74	84	NA	8.6	2.8
Total HI	[4]	13	28	31	65	71	74	84	NA	8.6	2.8
HI Only	[4]	1	1	2	6	8	5	7	NA	14.9	-2.2
Total SMI	[4]	12	27	29	59	63	69	77	NA	8.1	3.4
SMI Only [3]	[4]	NA	NA	0	NA	NA	0	0	NA	NA	NA

[1] Hospital insurance.

[2] Supplementary medical insurance.

TABLE 2-2--NUMBER OF MEDICARE ENROLLEES BY TYPE OF COVERAGE AND TYPE OF ENTITLEMENT, SELECTED YEARS 1968-2001-continued

[In Thousands]

[3] Disabled and end-stage renal disease only must have HI to be eligible for SMI coverage.

[4] Medicare disability entitlement began in 1973.

NA-Not available.

Source: Centers for Medicare & Medicaid Services.

TABLE 2-3--DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS BY TYPE OF COVERAGE AND SERVICE, SELECTED CALENDAR YEARS 1975-2002

[In millions of dollars]

Type of Coverage and Service	Amount and Distribution of Payments for Enrollees															
	1975		1980		1985		1990		1995		2000		2001		2002	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Total Payments	15,588	100.0	35,686	100.0	70,391	100.0	108,518	100.0	181,148	100.0	217,057	100.0	240,505	100.0	260,565	100.0
HI	11,315	72.6	25,051	70.2	47,444	67.4	66,050	60.9	116,176	64.1	126,505	58.3	137,796	57.3	148,523	57.0
Inpatient	10,877	69.8	24,116	67.6	44,940	63.8	59,383	54.7	81,984	45.3	87,280	40.2	95,586	39.7	104,907	40.3
SNF	254	1.6	395	1.1	548	0.8	2,620	2.4	9,236	5.1	10,928	5.0	13,448	5.6	14,646	5.6
HHA	104	0.7	540	1.5	1,913	2.7	3,689	3.4	16,373	9.0	3,902	1.8	4,239	1.8	5,138	2.0
Hospice	NA	NA	NA	NA	43	0.1	358	0.3	1,883	1.0	2,980	1.4	3,727	1.5	4,629	1.8
Managed Care	NA	NA	NA	NA	NA	NA	NA	NA	6,701	3.7	21,415	9.9	20,796	8.6	19,203	7.4
SMI	4,273	27.4	10,635	29.8	22,947	32.6	42,468	39.1	64,972	35.9	90,552	41.7	102,709	42.7	112,042	43.0
Physicians[1]	3,416	21.9	8,187	22.9	17,312	24.6	29,609	27.3	31,660	17.5	36,961	17.0	42,018	17.5	44,979	17.3
Outpatient Hospital	643	4.1	1,897	5.3	4,319	6.1	8,482	7.8	8,663	4.8	8,494	3.9	11,929	5.0	13,139	5.0
HHA	95	0.6	234	0.7	38	0.1	74	0.1	236	0.1	4,354	2.0	4,345	1.8	5,416	2.1

TABLE 2-3--DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS BY TYPE OF COVERAGE AND TYPE OF SERVICE, AND BY CALENDAR YEAR OR TYPE OF ENROLLEE- Continued

[In millions of dollars]

Type of Coverage and Type of Service	Amount and Distribution of Payments for Enrollees															
	1975		1980		1985		1990		1995		2000		2001		2002	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Group Practice Plan/ Managed care	80	0.5	203	0.6	720	1.0	2,827	2.6	6,610	3.6	18,358	8.5	17,560	7.3	17,497	6.7
Laboratory[2]	39	0.3	114	0.3	558	0.8	1,476	1.4	4,255	2.3	4,009	1.8	4,485	1.9	5,058	2.0
Other	NA	NA	NA	NA	NA	NA	NA	NA	13,548	7.4	18,376	8.5	22,372	9.3	25,954	9.9

HI- Hospital Insurance.
SNF- Skilled Nursing Facility.
HHA- Home Health Agency.
SMI- Supplementary Medical Insurance.
NA- Not applicable.
[1] Includes additional services.
[2] Independent laboratory services 1975-1990.

Source: Centers for Medicare & Medicaid Services.

BENEFITS AND BENEFICIARY COST-SHARING

PART A

Part A coverage includes:

Inpatient hospital care--The first 60 days of inpatient hospital services in a benefit period are subject to a deductible ($840 in calendar year 2003). A benefit period begins when a patient enters a hospital and ends when he or she has not been in a hospital or SNF for 60 days. For days 61-90 in a benefit period, a daily coinsurance amount ($210 in calendar year 2003) is imposed. When more than 90 days are required in a benefit period, a patient may elect to draw upon a 60-day lifetime reserve. A coinsurance amount ($420 in calendar year 2003) is imposed for each reserve day. No coverage is provided for stays in excess of 150 days in a benefit period.

Skilled Nursing Facility (SNF) care--The program covers up to 100 days of post-hospital SNF care for persons in need of continued skilled nursing care and/or skilled rehabilitation services on a daily basis. After the first 20 days, there is a daily coinsurance charge ($105 in calendar year 2003).

Home health care--Home health visits are provided to persons who need skilled care on an intermittent basis. The Balanced Budget Act (BBA) of 1997 gradually transferred from Part A to Part B home health visits that are not part of the first 100 visits following a beneficiary's stay in a hospital or SNF (i.e., postinstitutional visits) and during a home health spell of illness. Beginning January 1, 2003, Part A covers only postinstitutional home health services for up to 100 visits during a home health spell of illness, except for those persons with Part A coverage only, who are covered for services without regard to the postinstitutional limitation.

Hospice care--Hospice care services are provided to terminally ill Medicare beneficiaries with a life expectancy of 6 months or less for two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice interdisciplinary team must recertify, at the beginning of 60-day periods, that the beneficiary is terminally ill.

PART B

Part B of Medicare generally pays 80 percent of the approved amount (generally a fee schedule or other predetermined amount) for covered services in excess of an annual deductible ($100). Services covered include:

Doctor's services--This category includes surgery, consultation, and home, office and institutional visits. Certain limitations apply for services rendered by dentists, podiatrists, and chiropractors and for the treatment of mental illness.

Services of nonphysician practitioners--This category includes physician assistants, nurse practitioners, certified registered nurse anesthetists, clinical psychologists, and clinical social workers.

Other medical and health services--This category includes laboratory and

other diagnostic tests, x-ray and other radiation therapy, outpatient hospital services, rural health clinic services, DME, home dialysis supplies and equipment, artificial devices (other than dental), physical and speech therapy, and ambulance services.

Specified preventive services--These services include: an annual screening mammography for all women over age 40; a screening Pap smear and a screening pelvic exam once every 2 years, except for women who are at a high risk of developing cervical cancer; specified colorectal cancer screening procedures; diabetes self-management training services; bone mass measurements for high-risk persons; and prostate cancer screenings.

Drugs and vaccines--Generally Medicare does not pay for outpatient prescription drugs or biologicals. Part B does pay for immunosuppressive drugs following a covered organ transplant, erythropoietin (EPO) for treatment of anemia for persons with chronic kidney failure, and certain oral cancer drugs. The program also covers flu shots, pneumococcal pneumonia vaccines, and hepatitis B vaccines for those at risk. [Note: H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) provides for prescription drug benefits through Medicare.)

Home health services--Home health services include those not covered under Part A. (As noted above, BBA 1997 transferred some home health costs from Part A to Part B.) Part B also covers all medically necessary home health visits for persons not covered under Part A. The 20-percent coinsurance and $100 deductible do not apply for such benefits.

Table 2-4 illustrates the deductible, coinsurance, and premium amounts for both Part A and Part B services from the inception of Medicare.

FINANCING

The Medicare Hospital Insurance (HI) Trust Fund finances services covered under Medicare Part A. The Supplementary Medical Insurance (SMI) Trust Fund finances services covered under Medicare Part B. The trust funds are maintained by the Department of the Treasury. Each trust fund is actually an accounting mechanism; there is no actual transfer of money into and out of the fund. Income to each trust fund is credited to the fund in the form of interest-bearing government securities. The securities represent obligations that the government has issued to itself. Expenditures for services and administrative costs are recorded against the fund.

HOSPITAL INSURANCE TRUST FUND--INCOME

The primary source of income to the HI fund is HI payroll taxes. This source accounted for $152.7 billion (85.5 percent) of the total $178.6 billion in income for fiscal year 2002. Additional income sources include premiums paid by voluntary enrollees, government credits, interest on Federal securities, and taxation of a portion of Social Security benefits.

TABLE 2-4--PART A AND PART B DEDUCTIBLE, COINSURANCE, AND PREMIUMS,[1]
SELECTED YEARS 1966-2003

Calendar Year	Inpatient Hospital[2]			Skilled Nursing Facility 21st-100th day coinsurance per day[5]	HI Monthly Premium[6]			SMI deductible	SMI Premium	
	First 60 days deductible	61st-90th Day coinsurance per day[3]	60 Lifetime reserve days (nonrenewable) coinsurance per day[4]		Effective date	Full amount	Reduced amount		Effective date	Amount
1966	$40	$10	[7]	[7]	[8]	[8]	NA	$50	7/66	$3.00
1970	52	13	$26	$6.50	[8]	[8]	NA	50	7/70	5.30
1975	92	23	46	11.50	7/75	$40	NA	60	[8]	6.70
1980	180	45	90	22.50	7/80	78	NA	60	7/80	8.70
1985	400	100	200	50.00	1/85	174	NA	75	1/85	15.50
1990	592	148	296	74.00	1/90	175	NA	75	1/90	28.60
1991	628	157	314	78.50	1/91	177	NA	100	1/91	29.90
1992	652	163	326	81.50	1/92	192	NA	100	1/92	31.80
1993	676	169	338	84.50	1/93	221	NA	100	1/93	36.60
1994	696	174	348	87.00	1/94	245	$184	100	1/94	41.10
1995	716	179	358	89.50	1/95	261	183	100	1/95	46.10
1996	736	184	368	92.00	1/96	289	188	100	1/96	42.50
1997	760	190	380	95.00	1/97	311	187	100	1/97	43.80
1998	764	191	382	95.50	1/98	309	170	100	1/98	43.80
1999	768	192	384	96.00	1/99	309	170	100	1/99	45.50
2000	776	194	388	97.00	1/00	301	166	100	1/00	45.50
2001	792	198	396	99.00	1/01	300	165	100	1/01	50.00
2002	812	203	406	101.50	1/02	319	175	100	1/02	54.00
2003	840	210	420	105.00	1/03	316	174	100	1/03	58.70

[1] For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible for the year in which the services were furnished. For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began.

[2] For care in psychiatric hospital there is a 190-day lifetime limit.

[3] Always equal to one-fourth of inpatient hospital deductible through 1988 and for 1990 and later; eliminated for 1989.

TABLE 2-4--PART A AND PART B DEDUCTIBLE, COINSURANCE AND PREMIUMS[1]
SELECTED YEARS 1966-2003- continued

[4] Always equal to one-half of inpatient hospital deductible through 1988 and for 1990 and later; eliminated for 1989.

[5] Always equal to one-third of inpatient hospital deductible through 1988 and for 1990 and later. For 1989 it was equal to 20 percent of estimated Medicare covered average cost per day.

[6] Not applicable prior to July 1973. Applies to aged individuals who are not fully insured, and to certain disabled individuals who have exhausted other entitlement. The reduced amount is available to aged individuals who are not fully insured but who have, or whose spouse has or had, at least 30 quarters of coverage under title II of the Social Security Act. The reduced amount is 75 percent of the full amount in 1994, 70 percent in 1995, 65 percent in 1996, 60 percent in 1997, and 55 percent in 1998 and thereafter.

[7] Not covered.

[8] Not applicable.

NA-Not available.

Note-In addition to the deductible and coinsurance amounts shown in the table, the first three pints of blood are not reimbursed by Medicare. Currently there is no deductible or coinsurance on home health benefits. From January 1973 to June 30, 1982, there was a $60 annual deductible and prior to July 1, 1981, benefits were limited to 100 visits per benefit period under Part A and 100 visits per calendar year under Part B. Special limits apply to certain benefits: (1) outpatient physician services for mental illness; 50 percent of approved charges, up to a maximum of $250 in benefits per year, July 1, 1966 through December 31, 1987; $450 in benefits per year, January 1, 1988 through December 31, 1988; $1,100 in benefits per year, January 1, 1989 through December 31, 1989; beginning January 1, 1990, the limit was removed; (2) physical and occupational therapy services furnished by physical therapists in independent practice: maximum annual approved charges July 1, 1973 through December 31, 1981, $80 per year; January 1, 1982 through December 31, 1982, $400 per year; January 1, 1983 through December 31, 1989, $500 per year; January 1, 1990 through December 31, 1993, $750 per year; and January 1, 1994 through December 31, 1998; in 1999 there was an annual $1,500 limit on all physical therapy services (except those provided by a hospital) and an annual $1,500 limit on all occupational therapy services (except those provided by a hospital); and no limit in 2000, 2001, 2002, and January-August 2003.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

Payroll taxes

The HI Trust Fund is financed primarily through Social Security payroll tax contributions paid by employees and employers. Each pays a tax of 1.45 percent on all earnings in covered employment. The self-employed pay 2.9 percent. Prior to 1994, there was an upper limit on earnings subject to the tax. An upper limit ($87,000 in 2003) continues to apply under Social Security. Therefore incomes up to $87,000 have a combined tax rate of 7.65 percent (6.2 percent for Social Security and 1.45 percent for Medicare). Only the Medicare tax applies to any income in excess of $87,000.

Other income

The following are additional sources of income to the HI fund:

Railroad retirement account transfers--In fiscal year 2002, $425 million was transferred from the railroad retirement fund. This is the estimated amount that would have been in the fund if railroad employment had always been covered under the Social Security Act.

Reimbursements for uninsured person--HI benefits are provided to certain uninsured persons who turned 65 before 1968. Persons who turned 65 after 1967 but before 1974 are covered under transitional provisions. Similar transitional entitlement applies to Federal employees who retire before earning sufficient quarters of Medicare-qualified Federal employment provided they were employed before and during January 1983. Payments for these persons are made initially from the HI Trust Fund, with reimbursement from the general fund of the Treasury for the costs, including administrative expenses, of the payments. In fiscal year 2002, $442 million was transferred to HI on this basis.

Premiums from voluntary enrollees--Certain persons not eligible for HI protection either on an insured basis or on the uninsured basis described above may obtain protection by enrolling in the program and paying a monthly premium ($316 in 2003; for persons who have at least 30 quarters of covered employment, $174 in 2003). This accounted for an estimated $1.6 billion of financing in fiscal year 2002.

Payments for military wage credits--Periodic transfers are authorized between the general fund and the treasury and the HI trust fund, if needed, to adjust prior payments for the costs arising from wage credits granted to military service before 1957. The law authorizes a quinquennial adjustment to the amount transferred in 1983. No adjustment was made in FY 2002.

Tax on Social Security benefits--Beginning in 1994, the trust fund acquired an additional funding source. The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) increased the maximum amount of Social Security benefits subject to income tax from 50 to 85 percent and provided that the additional revenues would be credited to the HI Trust Fund. Revenue from this source totaled $8.3 billion in fiscal year 2002.

Interest--The remaining income to the trust fund consists almost entirely of interest on the investments of the trust fund. Interest amounted to an estimated $15.1 billion in fiscal year 2002.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND--INCOME

Part B is financed from premiums paid by the aged, disabled and chronic renal disease enrollees and from general revenues. The premium rate is derived annually based on the projected costs of the program for the coming year. The monthly premium amount in calendar year 2003 is $58.70.

When the program first went into effect in July 1966, the Part B monthly premium was set at a level to finance one-half of Part B program costs. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which Social Security benefits were adjusted for changes in cost of living (i.e., cost-of-living adjustments). Under this formula, revenues from premiums soon dropped from 50 to below 25 percent of program costs because Part B program costs increased much faster than inflation as measured by the Consumer Price Index (CPI) on which the Social Security cost-of-living adjustment is based. Beginning in the early 1980s, Congress regularly voted to set Part B premiums at a level to cover 25 percent of program costs, in effect overriding the cost-of-living adjustment limitation. BBA 1997 permanently set the Part B premium equal to 25 percent of program costs. General revenues cover the remaining 75 percent of Part B program costs

FINANCIAL STATUS OF HOSPITAL INSURANCE TRUST FUND

The Hospital Insurance (HI) Trust Fund balance is dependent on total income to the HI Trust Fund exceeding total outlays from the fund. Tables 2-5 and 2-6 show historical information from the 2003 Trustees' Report on the operation of the trust fund. Each year, the HI Trustees make projections for the date the trust fund will become insolvent (Table 2-7). The 1997 report stated that under the Trustees intermediate assumptions, the fund would become insolvent in 2001. Subsequent reports significantly delayed the projected insolvency date. However, the 2003 report projects that the fund will become insolvent 4 years earlier (2026) than had been projected in the 2002 report.

The initial improvements after 1997 reflected a number of factors including improvements in the economy as a whole (which were reflected in higher payroll tax revenues) and a lower rate of growth in program expenditures. A key factor was the enactment of BBA 1997. This legislation provided for the transfer of a portion of home health spending (which at the time was the fastest growing component of Part A expenditures) from Part A to Part B. It also included additional provisions to stem the growth in Part A expenditures. These provisions included the implementation of new payment limits for home health services, a prospective payment system (PPS) for skilled nursing facility (SNF) services, and limits on the increases in hospital payments. BBA 1997 also established the Medicare+Choice (M+C) Program and modified the calculation of payments to managed care entities.

TABLE 2-5--OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, SELECTED FISCAL YEARS 1970-2012

[In Millions of Dollars]

Fiscal Year[1]	Income								Disbursements			Net Increase in Fund	Balance at End of Year
	Payroll Taxes	From Taxation of Benefits	Railroad Retirement Account Transfers	Reim-bursement for Uninsured Persons	Premiums From Voluntary Enrollees	Payment for Military Wage Credits	Interest and Other Income[2]	Total	Benefits Payments[3]	Admini-strative Expenses[4]	Total		
1970	$4,785	NA	$64	$617	NA	$11	$137	$5,614	$4,804	$149	$4,953	$661	$2,677
1975	11,291	NA	132	481	$6	48	609	12,568	10,353	259	10,612	1,956	9,870
1980	23,244	NA	244	697	17	141	1,072	25,415	23,790	497	24,288	1,127	14,490
1985	46,490	NA	371	766	38	86	3,182	50,933	47,841	813	48,654	4,103[5]	21,277
1990	70,655	NA	367	413	113	107	7,908	79,563	65,912	774	66,687	12,876	95,631
1995	98,053	3,913	396	462	998	61	10,963	114,847	113,583	1,300	114,883	-36	129,520
1996	106,934	4,069	401	419	1,107	-2,293[6]	10,496	121,135	124,088	1,229	125,317	-4,182	125,338
1997	112,725	3,558	419	481	1,279	70	10,017	128,548	136,175	1,661	137,836	-9,287	116,050
1998	121,913	5,067	419	34	1,320	67	9,382	138,203	135,487[7]	1,653	137,140	1,063	117,113
1999	134,385	6,552	430	652	1,401	71	9,523	153,015	129,463[7]	1,978	131,441	21,574	138,687
2000	137,738	8,787	465	470	1,392	2	10,827	159,681	127,934[7]	2,350	130,284	29,397	168,084
2001	151,931	4,903	470	453	1,440	-1,175[8]	12,793	171,014	139,356[7]	2,368	141,723	29,290	197,374
2002	151,575	10,946	425	442	1,525	0	14,850	179,762	145,567[7]	2,464	148,031	31,731	229,105
2003	154,295	6,323	434	393	1,601	0	15,435	178,481	151,888[7]	2,772	154,661	23,820	252,926
2004	160,755	7,920	435	365	1,720	0	16,498	187,713	162,195	2,796	164,991	22,722	275,648
2005	172,103	8,952	444	200	1,828	0	17,922	201,448	172,219	2,869	175,088	26,360	302,009
2006	180,960	9,683	456	193	1,942	0	19,622	212,856	178,240	2,965	181,205	31,652	333,660
2007	191,435	10,526	472	200	2,066	0	21,496	226,195	190,544	3,063	193,607	32,588	366,248
2008	201,522	11,744	484	209	2,186	0	23,564	239,708	202,020	3,164	205,184	34,524	400,772
2009	211,646	13,097	496	219	2,317	0	25,661	253,436	214,925	3,274	218,199	35,237	436,010
2010	223,552	14,582	509	227	2,477	0	27,733	269,081	229,415	3,394	232,809	36,272	472,282
2011	235,320	16,580	523	234	2,638	0	29,758	285,053	247,384	3,524	250,908	34,145	506,426

TABLE 2-5--OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND,
SELECTED FISCAL YEARS 1970-2012- Continued

[In Millions of Dollars]

Fiscal Year[1]	Income								Disbursements			Net Increase in Fund	Balance at End of Year
	Payroll Taxes	From Taxation of Benefits	Railroad Retirement Account Transfers	Reim-bursement for Uninsured Persons	Premiums From Voluntary Enrollees	Payment for Military Wage Credits	Interest and Other Income[2]	Total	Benefits Payments[3]	Admini-strative Expenses [4]	Total		
2012	246,111	18,925	538	239	2,794	0	31,761	300,367	259,669	3,658	263,327	37,040	543,466

[1] Fiscal years 1970 and 1975 consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.

[2] Other income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and a small amount of miscellaneous income.

[3] Includes costs of peer review organizations from 1983 (beginning with the implementation of the prospective payment system on October 1, 1983) through 2001 and costs of quality improvement organizations beginning in 2002.

[4] Includes costs of experiments and demonstration projects. Beginning in 1997, includes fraud and abuse control expenses.

[5] Includes repayment of loan principal from the Old-Age and Survivors Insurance Trust Fund of $1,824 million.

[6] Includes the lump-sum general revenue adjustment of -$2,366 million.

[7] For 1998-2003, includes moneys transferred to the SMI Trust Fund for home health agency costs.

[8] Includes a lump-sum general revenue adjustment of -$1,177 million.

NA-Not applicable.

Note-Totals do not necessarily equal the sums of rounded components.

Source: Board of Trustees, Federal Hospital Insurance Trust Fund (2003).

TABLE 2-6--OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, SELECTED CALENDAR YEARS 1970-2012

[In Millions of Dollars]

Year	Income								Disbursements				
	Payroll Taxes	From Taxation of Benefits	Railroad Retirement Account Transfers	Reimbursement for Uninsured Persons	Premiums From Voluntary Enrollees	Payments for Military Wage Credits	Interest and Other Income[1]	Total	Benefits Payments[2]	Administrative Expenses[3]	Total	Net Increase in Fund	Balance at End of Year
1970	$4,881	NA	$66	$863	NA	$11	$158	$5,979	$5,124	$157	$5,281	$698	$3,202
1975	11,502	NA	138	621	$7	48	664	12,980	11,315	266	11,581	1,399	10,517
1980	23,848	NA	244	697	18	141	1,149	26,097	25,064	512	25,577	521	13,749
1985	47,576	NA	371	766	41	-719[4]	3,362	51,397	47,580	834	48,414	4,808[5]	20,499
1990	72,013	NA	367	413	122	-993[6]	8,451	80,372	66,239	758	66,997	13,375	98,933
1995	98,421	$3,913	396	462	954	61	10,820	115,027	116,368	1,236	117,604	-2,577	130,267
1996	110,585	4,069	401	419	1,199	2,293[7]	10,222	124,603	128,632	1,297	129,929	-5,325	124,942
1997	114,670	3,558	419	481	1,319	70	9,637	130,154	137,762	1,690	139,452	-9,298	115,643
1998	124,317	5,067	419	34	1,316	67	9,327	140,547	133,990[8]	1,782	135,771	4,776	120,419
1999	132,306	6,552	430	652	1,447	71	10,139	151,597	128,766[8]	1,866	130,632	20,965	141,380
2000	144,351	8,787	465	470	1,382	2	11,729	167,185	128,458[8]	2,636	131,095	36,090	177,475
2001	151,994	7,533	470	453	1,370	-1,175[9]	13,986	174,630	141,183[8]	2,195	143,379	31,521	208,726
2002	152,708	8,316	425	442	1,626	0	15,114	178,631	149,944[8]	2,582	152,526	26,105	234,831
2003	155,117	6,323	434	393	1,592	0	15,981	179,840	153,369[8]	2,765	156,134	23,705	258,537
2004	163,629	7,920	435	365	1,763	0	17,163	191,275	164,419	2,806	167,225	24,050	282,587
2005	173,701	8,952	444	200	1,849	0	18,749	203,894	172,648	2,890	175,538	28,357	310,944
2006	183,445	9,638	456	193	1,973	0	20,540	216,289	182,454	2,990	185,444	30,486	341,790
2007	194,050	10,526	472	200	2,097	0	22,519	229,865	193,382	3,087	196,469	33,396	375,185
2008	204,389	11,744	484	209	2,216	0	24,612	243,653	205,164	3,189	208,353	35,300	410,486
2009	215,021	13,097	496	219	2,351	0	26,702	257,885	218,506	3,302	221,808	36,078	446,563
2010	225,944	14,582	509	227	2,519	0	28,752	272,534	233,389	3,425	236,814	35,720	482,284

TABLE 2-6--OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, SELECTED CALENDAR YEARS 1970-2012- Continued

[In Millions of Dollars]

Calendar Year	Income								Disbursements			Net Increase in Fund	Balance at End of Year
	Payroll Taxes	From Taxation of Benefits	Railroad Retire-ment Account Transfers	Reimburs e-ment for Uninsured Persons	Premiums From Voluntary Enrollees	Payments for Military Wage Credits	Interest and Other Income[1]	Total	Benefits Payments[2]	Adminis-trative Expenses[3]	Total		
2011	237,346	16,580	523	234	2,677	0	30,765	288,124	249,461	3,557	253,018	35,106	517,390
2012	248,989	18,925	538	239	2,833	0	32,772	304,296	266,284	3,692	269,976	34,320	551,710

[1] Other income includes recoveries of amounts reimbursed from the trust fund, receipts from the fraud and abuse control program, which are not obligations of the trust fund and a small amount of miscellaneous income.

[2] Includes cost of peer review organizations from 1983 (beginning with the implementation of the prospective payment system on October 1, 1983) through 2001 and costs of quality improvement organizations beginning in 2002.

[3] Includes costs of experiments and demonstration projects. Beginning in 1997, includes fraud and abuse control expenses.

[4] Includes the lump-sum general revenue adjustment of -$805 million.

[5] Includes repayment of loan principal from the Old-Age and Survivors Insurance Trust Fund of $1,824 million.

[6] Includes the lump-sum general revenue adjustment of -$1,100 million.

[7] Includes the lump-sum general revenue adjustment of -$2,366 million.

[8] For 1998-2003, includes moneys transferred to the SMI Trust Fund for home health agency costs.

[9] Includes a lump-sum general revenue adjustment of $1,177 million.

NA-Not applicable.

Note-Totals do not necessarily equal the sums of rounded components.

Source: Board of Trustees, Federal Hospital Insurance Trust Fund (2003).

Following enactment of BBA 1997, a number of observers claimed that the actual savings achieved by BBA 1997 were larger than was intended when the legislation was enacted. As a result, legislation was enacted in 1999 (Balanced Budget Refinement Act of 1999 (BBRA)) and in 2000 (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)) which mitigated the impact of BBA 1997 on providers.

TABLE 2-7--HISTORICAL PROJECTIONS OF HI TRUST FUND INSOLVENCY, 1970-2003

Year of Trustees' Report	Projected Year of Insolvency	Projected Number of Years Until Insolvency
1970	1972	2
1971	1973	2
1972	1976	4
1973	none indicated	NA
1974	none indicated	NA
1975	late 1990s	NA
1976	early 1990s	NA
1977	late 1980s	NA
1978	1990	12
1979	1992	13
1980	1994	14
1981	1991	10
1982	1987	5
1983	1990	7
1984	1991	7
1985	1998	13
1986	1996	10
1986 amended	1998	12
1987	2002	15
1988	2005	17
1989	[1]	NA
1990	2003	13
1991	2005	14
1992	2002	10
1993	1999	6
1994	2001	7
1995	2002	7
1996	2001	5
1997	2001	4
1998	2008	10
1999	2015	16
2000[2]	2025	25
2001	2029	28
2002	2030	28
2003	2026	23

[1] Contained no long-range projections.

[2] As amended.

NA-Not applicable.

Source: Intermediate projections of various HI Trustees' Reports, 1970-2003.

The 2003 report projects a shift in direction. The Trustees project that HI tax income will fall short of outlays beginning in 2013, three years earlier than projected in 2002. The fund is expected to become insolvent four years earlier, 2026, rather than 2030. The change represents both a lower estimate of taxable wages resulting in lower taxable payroll and a higher estimate for hospital spending due to increases in admissions and increases in the average complexity of admissions.

Future operations of the trust fund will be very sensitive to future economic, demographic, and health cost trends and could differ substantially from the intermediate projections. Beginning in 2011, the program will begin to experience the impact of major demographic changes. First, baby boomers (persons born between 1946 and 1964) begin turning age 65. Second, there will be a shift in the number of covered workers supporting each HI enrollee. In 2002, there were about 4 workers for every beneficiary; in 2030 there will only be an estimated 2.4.

FINANCIAL STATUS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

Because the SMI Trust Fund is financed through beneficiary premiums and Federal general revenues, it does not face the prospect of depletion, as does the HI Trust Fund. However, the rising cost of the program is placing a burden on the trust fund, and by extension on beneficiaries (in the form of premiums) and Federal general revenues. Table 2-8 shows historical information from the 2003 Trustees' Report.

PART A SERVICES - COVERAGE AND PAYMENTS

HOSPITALS

Trends in Medicare Hospital Utilization and Spending

As shown in Table 2-9, Medicare program spending on hospital services has increased from approximately $77.8 billion in calendar year (CY) 1995 to $92.5 billion in CY2001, about a 19 percent change over the time period. The number of acute, short-term general hospitals paid under the inpatient prospective payment system (IPPS) has declined from 5,166 to 4,361, a drop of over 15 percent that can be attributed, in part, to hospital closures, mergers, and the growth in Medicare's critical access hospital program. Despite the drop in the number of IPPS hospitals, IPPS program spending has increased from over $69 billion in CY1995 to over $81 billion in CY2001, an increase of approximately 17 percent. In contrast to the overall decline in number of hospitals, the number of specialty hospitals, particularly long-term care hospitals but also rehabilitation hospitals and distinct part units, has increased. Medicare program spending, particularly in long-term care hospitals and in rehabilitation units, has increased significantly over the period. Table 2-10 shows hospital utilization for Medicare enrollees by type of hospital in CY2001. 96.4 percent of Medicare's hospital discharges were from IPPS hospitals

and averaged about $7,262 in program spending per discharge. Discharges from specialty hospitals comprised about 3.6 percent of total Medicare discharges in CY2001 and averaged about $9,178 in Medicare spending per discharge. Table 2-11 shows the Medicare hospital discharges as well as program and beneficiary payments from short-stay hospitals, ranked by diagnosis-related groups (DRGs), for FY2001. The top 25 DRGs represented 51.5 percent of total discharges and close to 53 percent of total payments to these hospitals. In fact, over 31 percent of the total discharges and almost 28 percent of the total spending is represented by the top 10 DRGs on the list. Finally, Table 2-12 shows the trends in factors affecting hospital expenditures, from FY1983 to FY2002. The annual update represents a payment-weighted average annual increase for IPPS hospitals and IPPS excluded hospitals. A hospital's case mix is a measure of the relative costliness and changes in coding of its Medicare patients compared with the national average. The change in case mix shown in the table represents the change in the average case mix for hospitals in one fiscal year compared to the preceding fiscal year. In FY2002, the average update received by hospitals was 2.56 percent, the case mix change for the average hospital increased 0.5 percent, and Medicare's average payment per discharge increased 5.04 percent.

Hospital payment systems

This section will discuss the major provisions establishing Medicare's payment systems for inpatient services provided by different types of hospitals. The section will first describe the separate operating and capital prospective payment systems (PPS) for acute inpatient care in short-term, general hospitals. Those costs that have been excluded from the inpatient PPS (IPPS) will then be described and this will be followed by a discussion of short-term hospitals that receive special treatment under IPPS: sole community hospitals (SCHs), rural referral centers (RRCs) and Medicare dependent hospitals (MDHs). Medicare's swing bed program which permits certain small rural hospitals to provide Medicare covered acute and post acute care in the same bed (that is, are permitted to swing the bed from providing acute care to post-acute care) and the critical access hospital (CAH) program where certain small, limited service facilities can now opt out of IPPS will then be discussed. Geographic reclassification procedures for IPPS hospitals will also be described. This will be followed by description of the payment systems used to pay those hospitals that were originally exempt from IPPS: inpatient rehabilitation facilities (including distinct part units in general hospitals), long-term care hospitals, psychiatric facilities (including distinct part units in general hospitals) and finally cancer and children's hospitals.

TABLE 2-8--OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), SELECTED FISCAL YEARS 1970-2012

[In Millions of Dollars]

Fiscal Year[1]	Income				Expenditures			Balance at End of Year[5]
	Premium From Enrollees	Government Contributions[2]	Interest and Other Income[3]	Total Income	Benefit Payments[4]	Administrative Expenses	Total Disbursements	
Historical data:								
1970	$936	$928	$12	$1,876	$1,979	$217	$2,196	$57
1975	1,887	2,330	105	4,322	3,765	405	4,170	1,424
1980	2,928	6,932	415	10,275	10,144	593	10,737	4,532
1985	5,524	17,898	1,155	24,577	21,808	922	22,730	10,646
1990	11,494[6]	33,210	1,434[6]	46,138[6]	41,498	1,524[6]	43,022[6]	14,527[6]
1995	19,244	36,988	1,937	58,169	63,491	1,722	65,213	13,874
1996	18,931	61,702	1,392	82,025	67,176	1,771	68,946	26,953
1997	19,141	59,471	2,193	80,806	71,133	1,420	72,553	35,206
1998	19,427	59,919	2,608	81,955	74,837[7]	1,435	76,272	40,889
1999	20,160	62,185	2,933	85,278	79,008[7]	1,510	80,518	45,649
2000	20,515	65,561	3,164	89,239	87,212[7]	1,780	88,992	45,896
2001	22,307	69,838	3,191	95,336	97,466[7]	1,986	99,452	41,780
2002	24,427	78,318	2,960	105,705	106,995[7]	1,830	108,825	38,659
Intermediate Estimates:								
2003	26,755	80,905	2,196	109,856	120,063[7]	2,139	122,202	26,313
2004	30,181	98,513	1,839	130,532	122,783[7]	2,328	125,112	31,734
2005	32,410	100,509	1,984	134,903	130,808	2,423	133,231	33,406
2006	34,462	106,333	2,204	143,000	136,059	2,527	138,586	37,820
2007	36,876	113,788	2,407	153,071	147,359	2,635	149,994	40,898
2008	39,710	122,373	2,610	164,693	158,426	2,746	161,172	44,419
2009	42,847	131,965	2,826	177,638	170,848	2,862	173,711	48,346
2010	46,347	142,668	3,056	192,071	184,674	2,981	187,655	52,763
2011	50,180	154,310	3,311	207,801	202,058	3,103	205,161	55,402
2012	54,355	167,036	3,592	224,983	214,547	3,231	217,777	62,609

[1] Fiscal years 1970 and 1975 consist of the 12 months ending June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.
[2] General fund-matching payments, plus certain interest-adjustment items.
[3] Other income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and other miscellaneous income.
[4] Includes costs of Peer Review Organizations from 1983 through 2001, and costs of Quality Improvement Organizations beginning in 2002.
[5] The financial status of SMI depends on both the assets and the liabilities of the trust fund.
[6] Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).
[7] Benefit payments less moneys transferred from the HI Trust Fund for home health agency costs, as provided for by the Balanced Budget Act of 1997.
Source: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund (2003).

TABLE 2-9--USE OF INPATIENT HOSPITAL SERVICES BY TYPE OF HOSPITAL, CALENDAR YEAR 2001

Type of Hospital	Number		Percentage Change 1995-2001	Program Payments (Thousands)		Percentage Change 1995-2001
	1995	2001		1995	2001	
All Hospitals	6,325	6,022	-4.8	$77,796,093	$92,546,774	19.0
Short-Stay Hospitals	5,221	4,425	-15.2	74,825,729	88,323,316	18.0
Hospitals Under IPPS	5,166	4,361	-15.6	69,279,252	81,052,957	17.0
Non-IPPS Hospitals and Units	--	--	--	5,546,477	7,270,360	31.1
Special Exclusion Status Hospitals	55	64	16.4	1,569,196	2,250,176	43.4
Psychiatric Units	1,426	1,436	0.7	1,840,090	2,254,273	22.5
Rehabilitation Units	831	936	12.6	2,137,190	2,765,910	29.4
Specialty Hospitals	1,104	1,597	44.7	2,970,364	4,223,458	42.2
Children’s Hospitals	69	75	8.7	24,831	24,131	-2.8
Psychiatric Hospitals	667	493	-26.1	885,655	606,733	-31.5
Rehabilitation Hospitals	190	216	13.7	1,293,442	1,474,704	14.0
Long-Term Care Hospitals	178	270	51.7	758,164	1,780,935	134.9
Critical Access Hospitals	NA	528	NA	NA	334,309	NA
Religious Nonmedical Health Care Institutions	NA	15	NA	NA	2,646	NA

Source: Centers for Medicare & Medicaid Services, Office of Research, Development and Information.

TABLE 2-10--USE OF INPATIENT HOSPITAL SERVICES BY TYPE OF HOSPITAL, CALENDAR YEAR 2001

Type of Hospital	Discharges			Covered Days of Care			Covered Charges				Reimbursement		
	Number of Hospitals	Number	Percent of Total	Number	Percent of Total	Per Dis-charge	Amount in (000)	Percent of Total	Per Dis-charge	Per Day	Amount in (000)	Per Dis-charge	Per Day
All Hospitals:	6,022	12,690,850	100.0	77,614,630	100.0	6.1	$235,188,032	100.0	$18,532	$3,030	$92,546,774	$7,332	$1,192
Short-Stay Hospitals	4,425	12,230,660	96.4	70,746,445	91.2	5.8	225,060,003	95.7	18,401	3,181	88,323,316	7,262	1,248
Hospitals Under IPPS	4,361	11,304,080	89.1	61,568,955	79.3	5.4	211,130,270	89.8	18,677	3,429	81,052,957	7209	1,316
Non-IPPS Hospitals and Units	-	926,580	7.3	9,177,490	11.8	9.9	13,929,733	5.9	15,033	1,518	7,270,360	7,902	792
Special Exclusion Status	64	265,580	2.1	1,470,850	1.9	5.5	2,864,199	1.2	10,806	1,947	2,250,176	8,496	1,530
Psychiatric Units	1,436	366,865	2.9	4,065,215	5.2	11.1	5,169,345	2.2	14,091	1,272	2,254,273	6,233	555
Rehabilitation Units	936	294,665	2.3	3,641,425	4.7	12.4	5,896,188	2.5	20,010	1,619	2,765,910	9,422	760
Specialty Hospitals	1,597	460,190	3.6	6,868,185	8.8	14.9	10,128,029	4.3	22,008	1,475	4,223,458	9,178	615
Children's Hospitals	75	1,930	0.0	13,155	0.0	6.8	63,379	0.0	32,839	4,818	24,131	12,503	1,834
Psychiatric Hospitals	493	114,280	0.9	1,623,140	2.1	14.2	1,420,878	0.6	12,433	875	606,733	5,309	374
Rehabilitation Hospitals	216	149,850	1.2	2,419,990	3.1	16.1	3,291,740	1.4	21,967	1,360	1,474,704	9,841	609
Long-Term Care Hospitals	270	90,280	0.7	2,460,315	3.2	27.3	4,780,128	2.0	52,948	1,943	1,780,935	19,727	724
Critical Access Hospitals	528	103,460	0.8	341,500	0.4	3.3	568,560	0.2	5,495	1,665	334,309	3,233	979
Religious Nonmedical Health Care Institutions	15	390	0.0	10,085	0.0	25.9	3,344	0.0	8,575	332	2,646	6,783	262

Note-Reimbursements represent program payments under regular Medicare fee-for-service for (1) IPPS hospitals, the DRG price plus outlier payments, net of inpatient and blood deductibles and coinsurance, plus the estimated pass-throughs and for (2) non-IPPS hospitals, the associated billing reimbursement.

NA- Not available.

Source: Centers for Medicare & Medicaid Services, Office of Information Services, unpublished data.

Operating prospective payment system

Medicare Part A pays for the operating costs associated with acute inpatient care in short-term hospitals using the inpatient prospective payment system (IPPS), established by Congress in the Social Security Amendments of 1983 (Public Law 98-21). Before the enactment of IPPS, Medicare paid hospitals retrospectively for incurred costs, subject to certain limits, definitions of allowable costs, and tests of reasonableness. Despite these limits, medical costs continued to grow faster than the rate of inflation in the early 1980s. IPPS was enacted to constrain the growth of Medicare's inpatient hospital payments by providing incentives for these acute hospitals to provide care more efficiently. Under IPPS, Medicare payments are made at predetermined, specific rates which represent the average cost, nationwide, of treating a Medicare patient according to his or her medical condition. Hospitals that are able to provide services for less than the fixed IPPS payment may keep the difference. Hospitals with costs that exceed the fixed IPPS payment lose money on the case. In general, the components of IPPS have served as a model for prospective payment systems subsequently developed for other types of hospitals.

The foundation for Medicare's prospective rates for both inpatient operating and inpatient capital payments is a patient classification system which now encompasses 518 diagnosis related groups (DRGs). A hospital's payment will vary depending upon the DRG assigned to a Medicare discharge. DRG assignment is primarily based on a patient's discharge diagnoses and type of treatment received (either medical or surgical with certain classifications dependent upon the hospital procedures provided during the stay). Depending upon the DRG, a patient's age, sex, and discharge destination may be considered as well. Each DRG has a relative value (or case-mix weight) that reflects the cost of treating Medicare patients in that particular group in comparison to the treatment cost of the average Medicare case. DRGs that are expected to use more resources than the average Medicare case have a relative value above one; those DRGs that are expected to be less costly have a value of less than one. The Centers for Medicare & Medicaid Services (CMS) annually reviews the DRG classification system to insure that clinically similar cases with relatively comparable costs are grouped together which may result in the reassignment of procedure codes to other DRGs as well as the creation or discontinuation of specific DRGs. For example, from FY2003 to FY2004, 5 DRGs were discontinued and 13 DRGs were created. CMS also recalibrates the relative values associated with each DRG annually using hospitals' average standardized billed charges for each DRG; such recalibration is subject to a budget neutrality adjustment to ensure that Medicare's aggregate payments do not increase because of the recalibrated DRG weights. The relative weight of any DRG may change from year to year. The weights for 223 DRGs for FY2004 declined from those for FY2003 (all but 38 DRGs by less than 5 percent) while the weights for 280 DRGs for FY2004 increased from those for FY2003 (all but 46 DRGs by less than 5 percent). Data for DRG relative weights may be found at http:www.cms.gov.

TABLE 2-11--MEDICARE SHORT-STAY HOSPITAL DIAGNOSIS-RELATED GROUPS RANKED BY DISCHARGE, FISCAL YEAR 2001

[In Thousands of Dollars]

Rank	DRG Number	Description	Discharges [1]	Percent Total	Total Payments[2]	Total Medicare Payments	Total Beneficiary Payments[3]
1	127	Heart Failure and Shock	686,830	5.6	$3,603,783	$3,258,989	$344,794
2	089	Simple Pneumonia and Pleurisy[4]	506,410	4.2	2,698,700	2,403,574	295,126
3	088	Chronic Obstructive Pulmonary Disease	399,849	3.3	1,829,334	1,604,216	225,118
4	209	Major Joint and Limb Reattachment Procedures	373,905	3.1	3,797,007	3,538,489	258,518
5	116	Other Permanent Cardiac Pacemaker Implant or Acid Lead or Generator Procedure	368,837	3.0	4,534,966	4,317,271	217,695
6	014	Specific Cerebrovascular Disorders Except Transient Ischemic Attack	324,461	2.7	1,988,094	1,786,815	201,279
7	430	Psychoses	323,840	2.7	2,063,592	1,863,347	200,245
8	462	Rehabilitation	280,502	2.3	2,670,173	2,611,264	58,909
9	182	Esophagitis, Gastroeneritis and Miscellaneous Digestive Disorders [4]	263,115	2.2	1,052,786	908,098	144,688
10	296	Nutritional and Miscellaneous Metabolic Disorders [4]	253,599	2.1	1,144,615	1,017,637	126,978
11	143	Chest Pain	252,329	2.1	690,693	532,888	157,805
12	174	Gastrointestinal Hemorrhage [5]	248,967	2.0	1,277,125	1,137,843	139,282
13	138	Cardiac Arrhythmia and Conduction Disorders [5]	204,852	1.7	867,051	752,577	114,474
14	320	Kidney and Urinary Tract Infections [4]	195,006	1.6	875,799	766,417	109,382
15	416	Septicemia, Age over 17	182,551	1.5	1,521,464	1,419,259	102,205
16	121	Circulatory Disorders with Acute Myocardial Infarction, with Cardiovascular Complications, Discharged Alive	168,331	1.4	1,328,266	1,238,997	89,269

TABLE 2-11--MEDICARE SHORT STAY HOSPITAL DIAGNOSIS-RELATED GROUPS RANKED BY DISCHARGE, FISCAL YEAR 2001- continued

[In Thousands of Dollars]

Rank	DRG Number	Description	Discharges [1]	Percent Total	Total Payments[2]	Total Medicare Payments	Total Beneficiary Payments[3]
17	079	Respiratory Infections and Inflammations [4]	167,416	1.4	1,437,822	1,349,403	88,419
18	132	Atherosclerosis with Complicating Conditions (CC)	153,664	1.3	504,555	424,515	80,040
19	015	Transient Ischemic Attack and Precerebral Occlusions	153,329	1.3	4,853,999	4,755,945	98,054
20	124	Circulatory Disorders excluding Acute Myocardial Infarction, with Diagnosis with Cardiovascular Catheter with Complex Diagnosis	138,328	1.1	995,290	917,917	77,373
21	148	Major Small and Large Bowel Procedures with CC	130,662	1.1	2,511,942	2,426,954	84,988
22	210	Hip and Femur Procedures except Major Joint[4]	122,481	1.0	1,110,702	1,032,861	77,841
23	316	Renal Failure	117,726	1.0	875,244	817,671	57,573
24	478	Other Vascular Procedures [5]	110,211	0.9	1,448,624	1,387,693	60,931
25	475	Respiratory System Diagnosis with Ventilator Support	104,740	0.9	2,188,472	2,121,352	67,120
Total, All DRGs			12,192,174	100.0	$90,427,469	$86,949,363	$3,478,106

[1] Based on the stay records for 100 percent of Medicare aged and disabled beneficiaries as recorded in the MEDPAR file.

[2] Total payments represent total hospital revenue for Medicare enrollee utilization, including Medicare payments and beneficiary obligations. Bills for no-pay, at-risk managed care utilization and no-pay Medicare secondary payer bills are excluded.

[3] Beneficiary payments are the responsibility of the beneficiary or other third party payers.

[4] Age greater than 17, with complications.

[5] With complications.

Source: Centers for Medicare & Medicaid Services, Office of Information Systems.

TABLE 2-12--TRENDS IN FACTORS AFFECTING MEDICARE HOSPITAL SPENDING AND AVERAGE PAYMENTS PER CASE, SELECTED FISCAL YEARS 1983-2002

[Percentage change from previous years]

Factor	1983	1985	1990	1995	1996	1997	1998	1999	2000	2001	2002
Market Basket index [1]	5.50	4.00	5.50	3.60 [2]	3.50 [3]	2.50	2.70	2.40	2.90	3.40	3.30
Annual update factor [4]	NA	NA	5.71	1.89	1.64	2.00	0.00	0.51	1.05	3.16	2.56
Case mix index [5]	--	3.10	0.85	1.50	1.40	0.20	-0.60	-0.50	-0.80	-0.70	0.50
Average payment per admission [6]	9.69	14.21	5.62	3.27	3.34	1.56	-0.25	3.25	-0.56	3.76	5.04
Average payment per beneficiary [7]	10.90	5.60	7.70	3.40	3.90	2.90	-2.00	-0.10	0.60	7.10	8.40

[1] Estimates based on data available when final PPS rule was issued for each fiscal year (except for 1985, which was before the start of the PPS; best available estimate for 1983 is shown). Estimates after the final rule can, and often do, differ from those shown.

[2] 3.7 for hospitals excluded from the prospective payment system.

[3] 3.4 for hospitals excluded from the prospective payment system.

[4] Estimate of the payment-weighted average update factor, as based on latest estimates, subject to change in future estimates. The estimates shown can, and often do, differ from those shown in the Federal Register notices announcing the inpatient hospital deductible each year. For 2001, one reason for the difference is that a change in the update factor was enacted to occur halfway through the fiscal year, which could not be known at the time of the deductible notice. The factor shown for 2001 is a payment-weighed average of all the update factors for the year.

[5] Estimated case mix index, as based on latest estimates. Subject to change in future estimates.

[6] Increases in fee-for-service incurred inpatient hospital expenditures on a per-charge basis, as estimated under the intermediate assumptions of the 2003 Trustees Report. Subject to change in future estimates.

[7] Increases in fee-for-service incurred inpatient hospital expenditures on a per-beneficiary basis, as estimated under the intermediate assumptions of the 2003 Trustees Report. Subject to change in future estimates.

NA – Not available.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

A hospital's DRG payment is the product of two components: (1) a standardized amount (or base rate) which is adjusted by the hospital's area average wage level; and (2) the DRG's relative weight. The base rate is intended to represent the cost of a typical (average) Medicare inpatient discharge. Presently, two separate standardized amounts are calculated: one amount is used to pay for Medicare discharges from hospitals in large urban areas (either metropolitan statistical areas that have a population of more than a million or New England County metropolitan areas that have a population of more than 970,000) and the other amount is used to pay for discharges from hospitals in other areas. The large urban area standardized amount is 1.6 percent larger than the other area amount. However, the Consolidated Appropriations Resolution, 2003 (CAR) (P.L.108-7) provided for a temporary payment increase for rural and small urban hospitals; all Medicare discharges from April 1, 2003 to September 30, 2003 were paid on the basis of the large urban area amount. The temporary authorization legislation that extended transitional Medicaid (P.L. 108-89) also extended Medicare's payment equalization between large urban hospitals and other hospitals until March 31, 2004. That law signed October 1, 2003 requires the Secretary to equalize the base amounts by November 1, 2003 and compensate hospitals for missed payments. Two amounts are still calculated for hospitals in Puerto Rico based on a 50/50 blend of a Federal amount and a Puerto Rico-specific amount.

The hospital wage index is used to adjust the standardized amount to account for the local wage variation or cost of labor in the hospital's area. This adjustment is accomplished by multiplying a portion of the national standardized payment amount by a wage index. Presently approximately 71 percent of the base rate is adjusted by the wage index. The wage index is intended to measure the average wage level for hospital workers in each urban area (metropolitan statistical area or MSA) or rural area (comprised of counties that have not been assigned to MSAs) relative to the national average wage level. Some states, such as New Jersey and Rhode Island, where every county is included in a MSA have no rural wage index.

The Secretary is required to update the wage index annually based on a survey of wages and wage-related costs of short-term acute care hospitals. An area's aggregate hospital compensation is divided by aggregate paid hours of hospital employment in the area to produce the area's average hourly wage. The area's wage index is calculated by dividing the average hourly wage for each area by the national average hourly wage (determined by dividing national aggregate compensation by national aggregate paid hours of employment). A wage index used to calculate a hospital's Medicare payment will be that index associated with the area where the hospital is located or that associated with the area where the hospital has been reclassified or redesignated. The index number, such as 0.7492 for hospitals in rural Alabama or 1.5119 for hospitals in Oakland, CA, for each rural area (or non-MSA) or MSA in the United States is published by CMS in the *Federal Register* in August of each year. A separate wage index for hospitals in Puerto Rico is calculated using only data from those hospitals as well. Any updates or adjustments to the wage index are done in a budget neutral fashion, so

that aggregate payments to hospitals are not affected by the annual changes.

Since the national average wage level is represented by an index value of 1.000, the wage index value for any area has a direct and simple interpretation. The value of 1.5119 for Oakland, CA means that the hourly wage rate for hospital workers is about 51 percent higher in that MSA than nationwide. In FY2004, the average annual wage in Oakland, CA was $36.87 and the national average hourly wage was $24.72. When computing the hospital payment rates applicable for hospitals in the Oakland, CA MSA, which has a population of more than 1 million, the labor-related share or 71 percent of the large urban area standardized amount is multiplied by 1.5119 in order to adjust for the higher level of hourly wage rates in this area. Similarly, the calculation of the per discharge payment for hospitals in rural Alabama would involve a reduction to the labor-related component of its standardized payment amount to reflect the fact that the average hourly wage in this area is $18.50 or about 25 percent lower than the national average (as indicated by the rural Alabama's wage index value of 0.7492). To calculate Medicare's base payment for hospitals in each of these areas, the nonlabor related share of the standardized amount is added to the wage-adjusted labor related share.

The calculation of the base payment amount for both areas is shown in Table 2-13**.** This amount would be multiplied by the applicable DRG weight to calculate Medicare's payment for a specific discharge.

TABLE 2-13--EXAMPLE OF WAGE-ADJUSTED PER DISCHARGE BASE IPPS PAYMENT CALCULATIONS FOR RURAL ALABAMA AND OAKLAND, CA FOR FISCAL YEAR 2004[1]

Component	Short-term general hospital in rural Alabama	Short-term general hospital Oakland, CA MSA
Labor-related share of national adjusted operating standardized amounts	$3,086.73 Other area amount	$3,136.39 Large urban area amount
Wage index for area	0.7492	1.5119
Wage-adjusted labor related share	2,312.58 [$3,086.73*0.7492]	$4,741.91 [$3,136.39*1.5119]
Nonlabor related share of national amounts	$1,254.67	$1,274.85
Wage-adjusted per discharge base payment	$3,567.25 [$2,312.58+1,254.67]	$6,016.76 [$4,741.91+$1,274.85]

[1] P.L. 108-89 provided for a temporary increase in the other area amount to the large urban amount for discharges from October 1, 2003 through March 31, 2004.

Source: CRS calculation based on information in FY2004 IPPS regulation published in the *Federal Register* on August 1, 2003 and subsequent correction notice issued October 6, 2003.

In general, the differences in the amount of these per discharge payments would reflect both the 1.6 percent differential in the standardized amount between large urban and other areas as well as the differences in the relative area wages. However, the 1.6 percent payment differential between the standardized amounts has been eliminated for discharges from October 1, 2003 until March 31, 2004. All hospitals will be reimbursed using the large urban area amount. Also, the per

discharge payments for hospitals in Alaska and Hawaii would reflect a cost-of-living adjustment to the nonlabor related portion of the standardized amount to recognize the higher cost of supplies and other nonlabor inputs. In FY2004, the nonlabor portion of the base rate (approximately 29 percent of the standardized amount) for hospitals in these states is increased by up to 25 percent.

Other Operating PPS Payment Adjustments--Factors other than a hospital's location will affect the amount of Medicare payment received for a particular DRG. In addition to the basic DRG payment for each case, teaching hospitals or those hospitals that serve a large number of Medicaid or poor Medicare beneficiaries may receive supplemental IPPS payments. Atypical or outlier cases may result in additional IPPS payments; under certain circumstances, cases that are transferred to other acute hospitals or certain post-acute settings may receive special treatment under IPPS. Finally, hospitals may receive additional payments to compensate for use of specifically identified new technologies.

Indirect Medical Education Adjustment--Medicare recognizes the costs of graduate medical education (GME) under two mechanisms: an indirect medical education (IME) adjustment within IPPS and, as discussed later, direct graduate medical education (DGME) payments made outside of IPPS. An IME adjustment provides additional IPPS payments to hospitals for the indirect costs attributable to approved medical education programs for physicians; Medicare does not recognize the indirect costs associated with the education of other health professions. A teaching hospital's higher patient care costs relative to nonteaching hospitals may be due to a variety of factors, including patient severity of illness that is not fully captured by the DRG patient classification system, the extra demands placed on the hospital staff as a result of the teaching activity, or additional tests and procedures that may be ordered by residents. About 1,100 hospitals, constituting about one fourth of all IPPS hospitals, receive IME payments. According to CBO's most recent estimate, Medicare's spending on IME for both operating and capital IPPS systems will be $6.1 billion in FY2003. This includes payments to teaching hospitals for patients enrolled in Medicare +Choice plans. MedPAC has found that Medicare's IME payments exceed the estimated cost relationship between teaching intensity and costs per case. Using 1999 cost data, MedPAC estimates that approximately half of the total IME payments in FY2003 are above the estimated impact of teaching on hospital costs.

A hospital's IME payment is based on a percentage add-on to the IPPS rate that is established by a complicated curvilinear formula that currently provides a payment increase of approximately 5.5 percent for each 10 percent increase in the hospital's intern and resident-to-bed (IRB) ratio. Hospitals with a higher IRB ratio, a measure of teaching intensity, receive a larger add-on adjustment to their DRG payments. For example, a hospital with 5 residents for every 100 beds (an IRB of 0.05) would have a 2.7 percent increase in its DRG payments; a hospital with 25 residents for every 100 beds (an IRB of 0.25) would receive a 12.8 percent IME adjustment to its DRG payments.

With certain exceptions, BBA 1997 limits the number of allopathic and osteopathic residents that Medicare will count in the IME formula (the numerator of

the IRB ratio) at the level reported by the hospital in its most recent cost report ending on or before December 31, 1996. Effective for cost reporting periods on or after October 1, 1997, the IME resident counts are based on a 3-year rolling average of the resident counts, subject to the resident limits or full-time equivalent (FTE) cap. If a hospital is above its limit, the count for the purposes of the rolling average is the FTE cap. In addition to the resident limit, BBA 1997 also placed a limit on the IRB ratio itself. A hospital's IRB ratio used to calculate its IME adjustment for the current payment year cannot exceed its IRB ratio from the immediately preceding cost reporting period.

Disproportionate Share Hospital Adjustment--Since 1986, an increasing number of hospitals have received additional payments because they serve a disproportionate share of low-income patients. The justification for DSH spending has changed over time. Originally, the DSH adjustment was intended to compensate hospitals that treat a large proportion of low-income patients for the higher costs associated with their treatment. Now, the adjustment is considered as a way to protect access to care for vulnerable populations.

Most DSH hospitals, approximately 2,800 hospitals, receive the additional payments based on a formula calculated using the proportion of the hospital's Medicare inpatient days provided to poor Medicare beneficiaries (those who receive Supplemental Security Income or SSI) added to the proportion of total hospital days provided to Medicaid recipients. A few urban 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.[1] CBO estimates that DSH spending (in both operating and capital PPS) will be $6.3 billion in FY2003

The DSH threshold is the minimum percentage of measured DSH care (measured under either the disproportionate day or Pickle formula) that must be provided by a hospital in order to qualify for additional payments. A hospital will not receive operating DSH payments unless its low- income patient share exceeds 15 percent or, as discussed earlier, it qualifies as a Pickle hospital. After that minimum threshold of 15 percent is met, a hospital's DSH adjustment, the percentage add-on to the hospital's IPPS payment, will vary by the hospital's bed size or urban or rural location. Under the current operating DSH thresholds and formulas, the DSH adjustment that a small urban or rural hospital can receive is capped at 5.25 percent while large (100 beds and more) urban hospitals and large rural hospitals (500 beds and more) can still receive an uncapped adjustment that can be significantly greater. However, certain rural hospitals, those that are sole community hospitals (SCHs) or rural referral centers (RRCs), may receive a higher DSH adjustment than other rural hospitals. Table 2-14 shows the minimum DSH thresholds required to qualify for the additional DSH payments and the formulas for computing the adjustment for different hospitals effective for discharges after April 1, 2001 authorized by the Medicare, Medicaid, and SCHIP

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[1] If a hospital receives at least 30 percent of its patient care revenue from these indigent care funds, it qualifies as a "Pickle" hospital and will get a 35 percent increase in its Medicare payments. Presently, 9 hospitals receive a DSH Medicare adjustment under the Pickle amendment.

Benefits Improvement and Protection Act of 2000 (BIPA).

TABLE 2-14--CURRENT OPERATING DISPROPORTIONATE SHARE THRESHOLDS AND FORMULAS, BY HOSPITAL TYPE AND SIZE, AS ESTABLISHED IN BIPA

Type and size of hospital		Threshold or qualifying DSH patient share	Adjustment formula
Urban	Less than 100 beds	DSH patient share greater than or equal to 15 percent but less than 19.3 percent.	Percent increase in IPPS payments based on [(P-15)*0.65] + 2.5.
		DSH patient share equal to or greater than 19.3 percent.	5.25 percent increase to a hospital's IPPS payments.
	100 or more beds	DSH patient share greater than or equal to 15 percent but less than 20.2 percent.	Percent increase in IPPS payments based on [(P-15)*0.65] + 2.5.
		DSH patient share equal to or greater than 20.2 percent.	Percent increase in IPPS payments based on [(P-20.2)*0.825]+ 5.88.
	100 or more beds	30 percent of inpatient revenue from State/local indigent care funds.	35 percent increase to a hospital's IPPS payments.
Rural	Under 500 beds (no distinction between under and over 100 bed rural hospitals)	DSH patient share equal to 15 percent but less than 19.3 percent.	Percent increase in IPPS payments based on [(P-15)*0.65] + 2.5.
		DSH patient share equal to or greater than 19.3 percent.	5.25 percent increase to a hospital's IPPS payments.
	500 or more beds	Not specified in law, regulations set at 15 percent.	Same as urban, 100 or more beds.
	Sole Community Hospital (SCH)	DSH patient share greater than 15 percent and less than 19.3 percent.	Percent increase in IPPS payments based on [(P-15)*0.65] + 2.5.
		DSH patient share equal to 19.3 percent but less than 30 percent.	5.25 percent increase to a hospital's IPPS payments.

TABLE 2-14--CURRENT OPERATING DISPROPORTIONATE SHARE THRESHOLDS AND FORMULAS, BY HOSPITAL TYPE AND SIZE, AS ESTABLISHED IN BIPA -continued

Type and size of hospital		Threshold or qualifying DSH patient share	Adjustment formula
		DSH patient share equal to or greater than 30 percent.	10 percent increase to a hospital's IPPS payments.
	Rural Referral Center (RRC), not SCH	DSH patient share greater than 15 percent but less than 19.3 percent.	Percent increase in IPPS payments based on [(P-15)*0.65] + 2.5.
		DSH patient share greater than 19.3 percent but less than 30 percent.	5.25 percent increase to a hospital's IPPS payments.
		DSH patient share equal to or greater than 30 percent.	Percent increase in IPPS payments based on [(P-30)*0.6] +5.25.
	Both RRC and SCH	DSH patient share equal to or greater than 15 percent.	Greater of a 10 percent increase or that resulting from [(P-30)*(0.6)] +5.25 Hospitals with DHS patient day proportion greater than 37.91 percent would be paid using the higher RRC adjustment.

Note-The disproportionate patient day proportion (P) is equal to the sum of (a) inpatient days provided to Supplemental Security Income beneficiaries divided by total Medicare inpatient days and (b) inpatient days provided to Medicaid recipients (who are not eligible for Part A) divided by total inpatient days.
Source: Congressional Research Service.

Outliers--Additional amounts are paid to hospitals for atypical cases known as "outliers." These are cases that have extraordinarily high costs compared to most discharges classified in the same DRG. Prior to FY1998 certain cases with extraordinarily long lengths of stay would have qualified for outlier payments as well. Outlier payments are financed by an offset or reduction in the base payment amount per discharge. The statute requires that total outlier payments to all hospitals covered by the system represent no less than 5 percent and no more than 6 percent of the total estimated PPS payments for the fiscal year. Generally, CMS has established 5.1 percent as the target for outlier spending.

To qualify as a cost outlier, a hospital's charges for a case, adjusted to its costs, must exceed a hospital's IPPS payment rate (including payments for IME, DSH, and for new technology) for the DRG by a certain threshold. Generally, the cost for a case is calculated by multiplying the charges for the inpatient stay by the hospital's ratio of cost to charges as reported in its most recent settled, or the most recent tentatively settled, cost report, whichever is from the later cost reporting period. The additional payment amount is equal to 80 percent of the difference

(90 percent for certain DRGs for burn victims) between the hospital's entire cost for the stay and the threshold amount. The threshold, which is adjusted by the hospital's wage index, is published every year in the *Federal Register*. For FY2004, the threshold is $31,000.[2]

Outlier payments have never equaled their targeted offset. In earlier years, Medicare underspent its target; most recently, outlier payments have exceeded the budgeted target, in part because of abrupt increases in certain hospitals' charges. CMS analyses indicates that years in which outlier payments have been more than expected have been offset by outlier spending in years when it has been less than expected. Since FY1997, however, actual outlier payments have exceeded the 5.1 percent offset by an aggregate of 11.2 percentage points; outlier spending has been $8.5 billion more than anticipated; an estimated $1.5 billion of that overspending occurred in FY2002. Total outlier spending in FY2002 is estimated to be approximately $5.4 billion. Certain changes, such as elimination of the use of statewide average cost to charge ratios and use of more recent hospital specific cost to charge ratios (from tentatively settled cost reports), in Medicare's outlier payment policies were instituted late in FY2003 or in FY2004 to address outlier overspending.

Transfers--Prior to BBA 1997, cases that were designated and reimbursed as transfer cases were for those patients that were discharged from one short-term general hospital and readmitted to another on the same day. Under the current payment policy for these cases, the sending acute hospital (the hospital that transfers the patient to another acute hospital) is paid twice the DRG per diem for the first day and the per diem for all remaining days up to the full payment amount. The final discharging acute hospital (the hospital that receives the patient) receives the full DRG payment amount.[3] Both hospitals remain eligible for cost outliers, DSH payments and GME payments for these transfer cases. The per diem payment is calculated as the hospital-specific DRG payment divided by the national geometric mean length of stay for all discharges in that DRG.

Patients discharged from an acute care hospital to postacute care settings were not initially included under this transfer policy. BBA 1997 directed that the Secretary select 10 DRGs with a high volume of discharges to postacute care or a disproportionate use of postacute services and pay these cases as transfers beginning in FY 1999. Postacute care includes those providers excluded from IPPS (including long-term care hospitals, inpatient rehabilitation facilities or distinct part units, psychiatric hospitals or units), skilled nursing facilities, and clinically related home health care provided within 3 days after the date of discharge. Acute patients in these DRGs that are transferred to swing beds for skilled nursing care are not considered to be postacute transfers. After FY 2000, the Secretary was authorized to expand this policy to additional DRGs. In FY2004, the transfer policy was modified to cover 29 DRGs; 2 of the original DRGs were eliminated and 21 other DRGs were added to the transfer policy. Generally, to be included under the

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[2] This single threshold applies to both capital and operating IPPS outlier payments.

[3] A sending hospital (as well as the final discharging hospital) will always receive full payment for a patient in one DRG who is transferred, DRG 385, Neonates that Died or Were Transferred.

policy, a DRG must have at least 14,000 postacute care transfer cases; at least 10 percent of its postacure care transfers occurring before the geometric mean length of stay; and a geometric mean length of stay of at least 3 days for both of the 2 most recent years for which data are available. For a new DRG to be included under this policy, its geometric mean length of stay must decline by at least 7 percent during the most recent 5-year period. To minimize coding distortions, CMS includes both DRGs from a paired DRG combination (where a patient's assignment in one or the other of the DRGs depends on the presence of a complication or comorbid condition) automatically under the policy even if only one of the DRGs meet these criteria.

Under the postacute transfer policy, the sending hospital will receive twice the per diem rate for the first day and the per diem rate for each following day of the stay up to the full DRG payment amount. However, 3 of the 29 selected DRGs have a disproportionate share of the costs early in the hospital stay. For these DRGs, a sending hospital receives 50 percent of the full DRG payment plus the per diem amount for the first day of the stay and 50 percent of the per diem amount for each of the remaining days of the stay, up to the full DRG payment. Medicare payment to any postacute providers involved in the stay are not affected by this policy.

Additional Payments for New Technology--BIPA established a process of identifying and paying more for new medical services and technologies provided to Medicare beneficiaries by short-term general hospitals. As defined by CMS, new technologies are those that represent an advance in medical technology that substantially improves diagnosis and treatment of Medicare beneficiaries when compared to previously available technologies. It takes 2 to 3 years from the point when a new technology is brought to market to the point where that data is incorporated in the Medicare charge data used to calculate DRG weights. To qualify for an additional IPPS payment, these technologies must be inadequately paid by the existing DRG system with costs that are not captured by the recalibration of DRG weights. As implemented by CMS, a new technology will qualify for special payments if the applicant can show that average charge for a case using the new technology is one standard deviation above the geometric mean of the standardized charges for all cases in the relevant DRG (or when a case may be assigned to multiple DRGs, the weighted average of all DRGs to which the case may be assigned). Medicare pays 50 percent of the costs of the new technology that are above the DRG payment, up to a maximum of 50 percent of the estimated cost of the new technology. The add-on payments are budget-neutral with a target limit of 1 percent of total operating prospective payments. If the target limit is exceeded, the marginal payment rate for new technologies would be reduced.

For FY2003, CMS received 5 applications for new technologies to be considered for the inpatient add-on payment; one biotechnology treatment for sepsis was approved for the add-on payment. However, in FY 2003, CMS recognized the likely introduction of a new technology in a different, unprecedented fashion. In that year, CMS created 2 new DRGs for patients receiving an angioplasty that uses drug-eluting stents, a higher cost technology that was

expected to be widely adopted once approved by the Food and Drug Administration (FDA). Subject to a positive decision by FDA, the DRGs became active for appropriate discharges occurring on or after April, 2003. CMS constructed the weights for the new DRGs using non-Medicare price data and utilization assumptions as explained in the August 1, 2003 *Federal Register*. For FY2004, CMS received 2 applications for new technologies to be considered for inpatient add-on payments and granted one for a spinal fusion technology. For FY2005 and in subsequent years, CMS has reduced the qualifying threshold to 75 percent of one standard deviation beyond the geometric mean standardized charges for all cases in the DRG to which the new medical service or technology is assigned.

Capital prospective payment system

Unlike the prospective payment systems that have been recently implemented for specialty hospitals, Medicare sets separate per discharge payment rates to cover the costs for depreciation, interest, rent and other property-related expenses in short-term general hospitals. Until FY1992, Medicare paid its share of acute hospitals' reasonable capital-related costs, based on the percentage of hospital services used by Medicare beneficiaries. Starting in FY1992, subject to a 10-year transition period extending through FY2001, inpatient capital costs were paid on the basis of an increasing proportion of an annual Federal rate and a decreasing proportion of a hospital's historic costs for capital. For all cost reporting periods beginning in FY 2002, all hospitals, except new hospitals, are paid based on 100 percent of the Federal rate.

As in the case with operating IPPS, standardized capital payment amounts are reduced to finance outlier payments and adjusted to account for the effect of DRG reclassifications and hospital reassignments, special exceptions payments as well as other mandated budget neutrality factors. In FY2004 the Federal rate for capital was set at about $427 for Medicare discharges from hospitals in large urban areas and about $415 for Medicare discharges from hospitals in other areas. Capital IPPS payments typically constitute about 10 percent of total Medicare IPPS inpatient payments to short-term hospitals for inpatient care, a percentage that has fluctuated over time and can vary by type and location of hospital.

Medicare's capital IPPS for acute hospitals includes similar adjustment factors as its operating IPPS; however, the adjustments in capital IPPS can be structured differently than those in the IPPS. Generally, under capital IPPS, the Federal rate is based on *average* base year capital costs per case in FY1989, updated by inflation and other cost changes. Hospitals in large urban areas receive an additional 3 percent increase to their Federal rate. Hospitals in Alaska and Hawaii receive an additional cost of living adjustment in capital IPPS.

Capital IPPS payments are adjusted using a hospital's geographic adjustment factor (GAF, which is calculated from the hospital's wage index) and Medicare patients' case-mix intensity which uses the same DRG patient classification system used in operating IPPS. Medicare's capital IPPS also incorporates special payments for outliers as well as payments for DSH and IME. With respect to outlier reimbursement, a single set of thresholds is used to identify outlier cases for both

inpatient operating and capital-related IPPS. Although the outlier reduction factor for operating IPPS is statutorily set between 5 percent and 6 percent, the outlier reduction factor for capital PPS is not. In FY2004, the capital outlier reduction factor was 4.79 percent.

With respect to the capital DSH adjustment, only urban hospitals with more than 100 beds may receive a DSH adjustment; there is no qualifying threshold specified. Rather, any hospital with a positive DSH percentage will receive approximately a 2.1 percent increase in its capital payments for each 0.01 increase in its DSH percentage. The "Pickle" hospitals (that qualify for a 35 percent operating DSH adjustment because at least 30 percent of their inpatient revenues are from State or local indigent care funds) are given a capital DSH adjustment of 14.16 percent.

With respect to the capital IME adjustment, teaching hospitals receive additional IPPS payments based on the ratio of residents to average daily inpatient census, rather than the ratio of residents to beds as in operating IPPS. The adjustment factor will increase capital payments approximately 2.8 percentage points for each 10 percent increase in this IME measure.

Finally, capital IPPS incorporates special exception payments for different categories of hospitals. CMS has established a special exceptions process which provides for additional payments to eligible hospitals for up to 10 years from the year that it completes a replacement or renovation project that meets certain criteria. The project must have been completed no later than the end of the hospital's last cost reporting period before October 1, 2001. Eligible hospitals include sole community hospitals; urban hospitals with at least 100 beds with a minimum DSH adjustment of 20.2 percent; hospitals that receive DSH as a Pickle hospital; and hospitals that have a combined Medicaid and Medicare utilization of at least 70 percent. These hospitals must meet specified project need and project size requirements. CMS estimates that 27 hospitals will qualify for special exception payments in cost reporting periods beginning in FY 2000.

Capital exception payments are also made to hospitals that incur unanticipated capital expenses due to circumstances beyond the hospital's control. Specifically, these would include unanticipated capital expenditures in excess of $5 million (net of insurance proceeds or other Federal or State monies) attributed to extraordinary circumstances including floods, fires, or earthquakes. Hospitals will receive a minimum of 85 percent of Medicare's share of the allowable capital-related costs attributed to these circumstances. SCHs will receive at least 100 percent of these allowable costs.

Annual Updates

The IPPS standardized amounts are increased each year using an update factor which may be determined, in part, by the projected increase in the hospital market basket (MB) index. CMS rebases the operating MB index every 5 years to reflect the changing composition of hospital inputs being purchased. Most recently, the MB was rebased and revised for FY2003 payments to reflect FY1997 cost data and to incorporate a separate category for blood and blood products.

The hospital input price index reflects the average change in the price of a set of mutually exclusive spending categories. The relative importance of the spending categories (cost or expenditure weights) are calculated using Medicare cost reports and other data from a base year. These are the numerical shares that each category contributes to the total MB; the cost weights over all categories add up to 100 percent. The more that an input good is used in the production of inpatient hospital care, the higher the associated expenditure weight will be and the greater the influence the projected inflation in that category will have on the change in the MB. Price proxies (or measures of price inflation) are selected for each spending category. The proxies are derived from publicly available statistical series published on a routine basis, preferably no less often than each quarter. For example, the proxy selected for the wages and salary expense category is the employment cost index for civilian hospital workers. To calculate the MB, the weight for each category is multiplied by the level of the price proxy. The sum of these products for all cost categories equals the composite index level of the MB in a given year. Dividing this sum by the index level from an earlier year produces an estimate of the growth rate in the MB over that time period. As shown in Table 2-15, the projected inflation of 3.8 percent for wages and salaries comprise 50.69 percent of the estimate of total hospital operating MB used to set the FY2004 IPPS rates.

Generally, Congress sets the update for operating payments for several years in advance in statute. According to CMS, the IPPS update is the single most important payment variable for the hospital sector as it affects nearly $100 billion per year in Medicare hospital payments. Typically, over the life of IPPS, the operating update has been set at a level below a full MB update. For example, in FY2003, the update for operating costs was set at MB - 0.55 percentage points; the best estimate of the MB available when the final regulation was issued was 3.5 percent. The FY2003 update equaled a 2.95 percent increase. However, for FY2004 and in subsequent years, absent further legislation, the operating update will equal the change in the MB. The MB update reflected in the IPPS operating update each year is the most recently available forecast when the final regulation is published. Unlike the capital IPPS update, the operating update does not include a correction for forecast error. As indicated by Table 2-16, for most of IPPS, the forecasted value of the MB incorporated in the IPPS update has been larger than the final estimate of the MB change.

TABLE 2-15--INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM INPUT PRICE INDEX ("THE MARKET BASKET") EXPENSE CATEGORIES AND RATES OF CHANGE, FOR EACH PRICE PROXY, FISCAL YEAR 2004

Expense Category	Federal Fiscal Year Percentage Rates of Price Change	
	Base Year 1997 weights [1]	2004 [2]
Wages and Salaries [3]	50.69	3.8
Employee Benefits [3]	10.97	4.9
Professional fees: Non-Medical [3]	5.40	3.5
Utilities	1.35	-1.0
Electricity	0.83	-1.6
Fuel, Oil, Coal, Etc	0.28	-2.0
Water and Sewage	0.24	2.6
Liability Insurance	0.84	6.3
All Other	30.75	2.2
All other Products	19.54	2.0
Pharmaceuticals	5.42	3.9
Food: Direct Purchase	1.37	1.5
Food: Contract Service	1.27	2.6
Chemicals	2.60	-1.9
Blood and Blood Products	0.88	1.0
Medical Instruments	2.19	1.8
Photographic Supplies	0.20	1.3
Rubber and Plastics	1.67	1.5
Paper Products	1.36	3.1
Apparel	0.58	0.1
Machinery and Equipment	1.04	0.1
Miscellaneous	0.96	1.4
All other Services	11.21	2.7
Telephone	0.40	0.3
Postage	0.86	1.8
All Other: Labor Intensive [3]	5.44	3.3
All Other: Non-Labor Intensive	4.52	2.2
Total	100	3.4

[1] Weights may not sum due to rounding.
[2] Projected data, subject to change in future forecasts, used to establish FY 2004 IPPS rates.
[3]Considered labor related.
Source: Center for Medicare & Medicaid Services, Office of the Actuary.

Although Congress sets the operating update, CMS sets the capital update using an update framework that consists of a capital input price index (CIPI) and several adjustment factors. In FY2003, CMS rebased and revised the CIPI to incorporate a FY1997 base year and to reflect a more recent structure of capital costs. The capital price index is structured differently from the operating MB, because capital is acquired and paid for over time instead of being consumed in the same time period in which it is purchased. The CIPI incorporates 2 sets of weights: one set identifies the relative importance of each of the cost categories to the average capital costs in a hospital and the other set of weights (called vintage weights) identifies the proportion of capital spending within each cost category that is attributable to each year of the useful life of the capital asset. The capital cost

categories include depreciation (physical capital including both building and fixed equipment as well as moveable equipment), interest (financial capital) and other related capital expenses (such as insurance). With respect to the relative importance of each of the capital cost categories, depreciation of building and fixed equipment comprises 34.22 percent of the CIPI; depreciation of movable equipment comprises 37.13 percent of the CIPI and interest costs comprises 23.46 percent of the CIPI. Lease expenses are not a separate cost category in the CIPI, but are distributed among the other capital cost categories with 10 percent of lease costs assumed to be overhead.

TABLE 2-16--FORECASTED INCREASE IN THE IPPS MARKET BASKET, ACTUAL INCREASE IN THE IPPS MARKET BASKET, AND THE IPPS UPDATE, FISCAL YEARS 1984-2002

Fiscal Year	Forecasted Increase in the IPPS Market Basket[1]	Actual Increase in the IPPS Market Basket[2]	Actual IPPS Operating Update
1984	4.9	5.1	4.7
1985	4.0	4.0	4.5
1986	4.3	3.0	0.5
1987	3.7	3.3	1.2
1988[3]	4.7	4.8	1.5
1989	5.4	5.5	3.3
1990	5.5	4.6	4.7[4]
1991	5.2	4.4	3.4
1992	4.4	3.2	3.0
1993	4.1	3.1	2.7
1994	4.3	2.6	2.0
1995	3.6	3.1	2.0
1996	3.5	2.4	1.5
1997	2.5	2.0	2.0
1998	2.7	2.9	0.0
1999	2.4	2.5	0.5
2000	2.9	3.6	1.1
2001	3.4	4.1	3.4
2002	3.3	2.9	2.75
2003	3.5	N/A	2.95
2004	3.4	N/A	3.4

[1] Projected forecast of MB based on available data when final rule was published that was used to set update for that year.
[2] Final measure of MB increase for a given year.
[3] IPPS was implemented in 1984, but was not fully-phased in until 1988. Also, throughout IPPS the hospital categories that determined the standardized rate paid to a hospital changed: from an urban/rural configuration to large urban/ urban/ rural and now to large urban/other area. Actual updates received by any hospital would be affected these changes.
[4] Actual updates for FY1990 adjusted to reflect 1.22 percent across the board reduction in DRG weights.
Source: Centers for Medicare & Medicaid Services, various publications.

CMS sets the capital update using their update framework which includes the CIPI rate of increase adjusted for patient care intensity (or efficiency) changes, case-mix adjustments, DRG reclassifications and recalibrations and a correction for the forecast error from 2 years earlier. CMS includes an intensity adjustment to

reflect policy considerations with respect to assessed improvements in efficiency, within-DRG severity increases and the adoption of quality enhancing technology. Other adjustments within the update framework are based on CMS's attribution of the source of observed changes in the case-mix index for Medicare discharges. The change in the case-mix index can result from changes in the average resource use of Medicare patients (a "real" case-mix change), changes in hospital coding practices that would result in higher weight DRG assignments (coding effects), and changes in DRG reclassification and recalibration. To the extent that the real case-mix increase is captured by the observed change in the case mix index measure, no additional adjustment will be incorporated in the capital update framework. Also, the DRG reclassification effect is included with a 2-year lag. For example, the FY2003 capital update framework included a -0.3 percent reduction attributed to an overstatement of the change originally attributed to DRG recalibration and reclassification that occurred in FY2001. Finally, CMS will make an adjustment for forecast error if their estimate of the CIPI for any year is off by 0.25 percentage points or more; again there is a 2-year lag between the forecast and the measurement of forecast error. For example, the -0.3 percent forecast correction factor in FY2003 indicates that the current data establishes that the forecasted value of the CIPI used in the FY2001 update framework was overstated. The impact of the policy adjustments vary from year to year. For example, in FY2003, the CIPI was 0.7, but the capital update was 1.1 percent due to the influence of other factors. However in FY2004, the capital update was 0.7 percent, an increase that was entirely driven by the rate of change in the CIPI; other adjustments were deemed to either have a negligible impact or cancelled each other out. Table 2-17 shows the capital update framework and associated adjustments from FY1999 to FY2004.

TABLE 2-17 -- CAPITAL IPPS UPDATE FRAMEWORK, FISCAL YEARS 1999-2004

Capital Update Components	1999	2000	2001	2002	2003	2004
Capital Input Price Index	0.7	0.6	0.9	0.7	0.7	0.7
Intensity	0.0	0.0	0.0	0.3	1.0	0.0
Projected Case-mix Change	-1.0	-0.5	-0.5	0.0	-1.0	-1.0
Real DRG Change	0.8	0.5	0.5	0.0	1.0	1.0
Subtotal	0.5	0.6	0.9	1.0	1.7	0.7
Effect of Reclassification and Recalibration (with 2 year lag)	0.0	0.1	0.0	0.0	-0.3	0.0
Forecast Error Correction (with 2 year lag)	-0.4	-0.4	0.0	0.3	-0.3	0.0
Total Capital Update	0.1	0.3	0.9	1.3	1.1	0.7

Source: CRS compilation of data from various *Federal Registers.*

For both operating and capital IPPS, the annual increase to the base rates will depend not only on the update amounts, but will also be affected by the annual budget neutrality offsets attributed to DRG recalibrations, wage index changes, hospital reclassifications, and outliers.

Payments made outside capital and operating IPPS

Specific categories of hospital expenses, including direct medical education costs, are not included in the hospital prospective payment system.

Direct medical education costs--The direct costs of approved medical education programs (such as the salaries of residents and teachers and other education costs for residents, for nurses, and for allied health professionals trained in provider-operated programs) are paid separately from IPPS. The direct medical education costs for the training of nurses and allied health professionals in provider-operated programs are paid for on a reasonable cost basis. The direct costs of residency training programs for physicians are paid according to a formula that uses each hospital's per resident costs, updated from a base year and subject to certain limits as explained below. CMS estimates Medicare spending on direct graduate medical education (DGME) payments for allied health professionals at $250 million for fee-for-service beneficiaries and an additional payment of up to $60 million made to hospital-based nursing and allied health programs to account for utilization by beneficiaries who are enrolled in Medicare+Choice programs; CMS estimates Medicare spending on DGME payments for residency training programs for physicians at $2.3 billion in FY2002.

Medicare's payment to each hospital for the direct costs of physician's residency training programs equals the hospital's cost per full-time equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare Part A beneficiaries, including days provided to Medicare +Choice enrollees. Generally, each hospital's per resident amount (PRA) is calculated using data from the hospital's cost reporting period that began in fiscal year 1984, increased by 1 percent for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the Consumer Price Index (CPI). Hospitals with both primary care and obstetrics and gynecology residents and nonprimary care residents in FY1994 or FY1995 may have two separate PRAs: one for primary care and obstetrics and gynecology and one for nonprimary care. Primary care residents are defined to include family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, and osteopathic general practice.

Although teaching hospitals' per resident costs vary greatly between hospitals, recently some of the variation in Medicare reimbursement for these amounts has been reduced. Starting in FY2001, hospitals with PRAs below 70 percent of the national average were increased to 70 percent of the geographically adjusted value or the floor amount. Starting during FY2002, this floor was increased to 85 percent of the locality adjusted, updated, and weighted national PRA. Also hospitals with PRAs above 140 percent of the geographically adjusted national average or the ceiling amount did not receive an inflation update for 2 years (FY2001 and FY2002) and will receive a lower update than other hospitals (CPI minus 2 percent) for 3 years (FY2003- FY2005).

Only residents in their initial residency period are counted as a full FTE. Residents who are not in their initial residency period are counted as one-half of an FTE. There is no limit on the number of years that an individual resident can be

counted as 0.5 FTE as long as the resident continues to train in an approved program. Generally, the initial residency period is the minimum number of years required for a resident to become board eligible in the specialty in which the resident first began training, not to exceed 5 years. The number of years considered as an initial residency period varies by physician specialty. The initial residency program in combined residency programs is defined as the time required for certification in the longer of the programs. In certain combined programs, an additional year in the initial period is permitted. Residents who are foreign or international medical graduates are not counted as FTE residents unless they have passed certain examinations.

In general, Medicare's DGME payment to any hospital is limited by a cap that is based on the number of allopathic and osteopathic residents that the hospital counted for the purposes of DGME payments on its cost report ending on or before December 31, 1996. Generally, a hospital's unweighted FTE count may not exceed this limit, but certain adjustments may be made for newly established medical residency training programs, terminations of teaching programs, rural training programs, and affiliated groups of teaching hospitals. A hospital's DGME payments are based on a 3-year rolling average of resident counts (using data from the payment year cost reporting period and the preceding two cost reporting periods), subject to the resident limits. This rolling average calculation will include dental and podiatry residents.

Payments for Other Excluded Cost Categories--Certain hospitals receive additional payments for different categories of services that have been excluded from IPPS and are paid separately. Medicare pays for a percentage of the bad debts attributable to unpaid deductible and copayment amounts related to covered services received by Medicare beneficiaries. In FY1998, approximately 3,900 hospitals received $409 million in bad debt payments. The estimated net expenses associated with Medicare organ acquisition in certified transplantation centers are excluded from IPPS and paid on a reasonable cost basis. In FY1998, 208 hospitals received about $340.3 million for net organ acquisition costs. Qualifying rural hospitals are paid on a reasonable cost basis for anesthesia services furnished by hospital employed nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologist's assistants) or obtained under arrangement. In FY1999, 639 hospitals received approximately $33.9 million in Medicare payments for these services. Finally, teaching hospitals can elect to receive reasonable cost payments in lieu of fee schedule payments that might otherwise be made for direct medical and surgical services of physicians who are employees or who otherwise agree not to bill separately for such services. The services include the services and the supervision of interns and residents providing care to Medicare beneficiaries. In FY1998, 14 teaching hospitals were paid about $25.6 million for these services.

Special Treatment for Certain Acute Care Facilities--Certain facilities receive special treatment under IPPS, particularly those facilities identified as isolated or essential hospitals primarily located in rural areas, including rural referral centers, sole community hospitals, and Medicare dependent hospitals. Small rural facilities have been able to offer long-term care services without

establishing a distinct unit by offering such care in hospital swing beds (beds that swing between offering acute care and long-term care services.) Starting in 1998, small, limited service facilities have been able to opt out of Medicare IPPS under the critical access hospital program and receive reasonable cost reimbursement for their services.

Sole Community Hospitals (SCHs)--SCHs are hospitals that, because of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of inpatient services reasonably available in a geographic area. Any hospital seeking SCH status can qualify if it is located more than 35 miles from a like hospital. Depending upon its circumstances, including its bed size, a hospital can qualify as a SCH under various distance, market share or travel time standards. Specifically, a hospital that is located more than 35 miles from other like hospitals or one with at least 45 minutes of travel time between it and its nearest like hospital because of distance, posted speed limits, and predictable weather conditions will qualify as a SCH. A rural hospital that is located between 25 and 35 miles from another like hospital can qualify as a SCH if it: (1) passes a market share test where no more than 25 percent of the Medicare beneficiaries or population within its service area can be admitted to other like hospitals located within a 35-mile radius or in its service area, whichever is larger; (2) has fewer than 50 beds, does not offer specialty services that are needed by some of the Medicare beneficiaries or other residents in its service area, and has its Medicare fiscal intermediary certify that it would have otherwise met the market share test if it did offer the needed services; or (3) had its like hospitals inaccessible for at least 30 days in each 2 out of the 3 preceding years. For these purposes, a hospital's service area is defined, generally speaking, as the smallest number of zip codes from which it draws 75 percent of its admissions during the most recent 12-month cost reporting period ending before its SCH application. A rural hospital that is located between 15 and 25 miles from other like hospitals can qualify as a SCH if its other like hospitals are inaccessible for at least 30 days in each 2 out of the 3 preceding years.

The rural SCH qualification criteria may be applicable to urban hospitals. BBRA provided that an urban hospital may be redesignated as being located in a rural area if it meets one of several criteria. Specifically an urban hospital can apply to the Secretary and be reclassified to a rural area if (1) it is in a rural census tract of a metropolitan area; (2) it is designated by the State as in a rural area or as a rural hospital; or (3) it meets all the requirements for rural SCHs except that it is located in an urban area. An urban hospital that qualifies as a rural SCH and reclassifies to a rural area through this process is not permitted to be reclassified subsequently through the Medicare Geographic Classification Review Board (MGCRB).

CMS does not consider all providers offering inpatient services to be "like hospitals" when determining whether an applicant can qualify as an SCH. Specifically, critical access hospitals (CAHs) are not considered like hospitals by CMS, because these facilities are not full-service inpatient providers. Moreover, CMS will not consider a nearby hospital to be a like hospital unless the inpatient

services provided by the nearby hospital "overlap" with those offered by the SCH or SCH applicant. As established in regulation, effective for cost reporting periods on or after October 1, 2002, a nearby hospital will not be considered a like hospital unless the percentage of its total inpatient days equals 8 percent or more of the total patient days provided by the SCH or SCH applicant. The comparison includes all days provided in units that provide the level of care payable under IPPS; days provided in PPS-exempt, distinct part units would not be included in the comparison. This regulatory provision was adopted because of the development of freestanding specialty hospitals that focus on specific cardiovascular, orthopedic, or other surgical procedures.

The primary advantage of the SCH classification is the option to use a hospital's updated historical operating costs when calculating Medicare inpatient payments when this results in higher payments to the hospital. Specifically, an SCH may use the higher of the following payment rates as the basis of its Medicare reimbursement: the current IPPS base payment rate in comparison to its hospital-specific per discharge costs from either FY1982, FY1987, or FY1996 updated to the current year. The FY1996 base year option became effective for discharges on or after FY2001 on a phased-in basis and is fully implemented for SCH discharges beginning in FY2004. An SCH will only receive outlier payments, disproportionate share hospital payments, or indirect medical education payments (adjustments within the IPPS system) when it is paid using the current IPPS base rate (and not the rates based on its updated hospital specific per discharge costs). An SCH's Medicare payments will be calculated using the rate that results in the highest payment as established by its fiscal intermediary in the settlement of the hospital's cost report.

Another significant advantage for an SCH is the ability to request additional payments for any year if the hospital experiences a decrease of more than 5 percent in its total inpatient cases due to circumstances beyond its control. The request must include an analysis of the reasons for the decrease in discharges, explain the resulting effect on the per discharge costs, and show that the decrease is due to circumstances beyond the hospital's control. There are other special inpatient payment considerations an SCH may receive. Specifically, those rural SCHs that are paid on the basis of the current IPPS base rate (and not on the basis of their hospital-specific costs) that qualify for disproportionate share hospital (DSH) payments will receive a 10 percent payment increase rather than the maximum 5.25 percent DSH adjustment received by other rural hospitals. Moreover, SCHs are not required to meet one of the tests, the proximity requirement, in order to reclassify to a different geographic area and receive a higher wage index, base payment rate (if applicable) or both. In terms of payments for outpatient services, the outpatient laboratory fee schedule can be increased by 2 percentage points for these services provided by an SCH.

Certain SCHs not meeting the criteria have been allowed to continue to qualify for payments as an SCH. Under most circumstances, hospitals designated as SCHs prior to December 19, 1989 are permitted to retain their SCH status. Generally, an approved SCH classification will remain in effect without the need

for approval unless there is a noticeable change in the circumstances under which the classification was approved. However, a hospital (even a "grandfathered" SCH) can lose its special status as an SCH if successfully reclassified by the MGCRB for the purposes of using a higher base payment.

Medicare Dependent Hospitals--Small rural hospitals that treat a relatively high proportion of Medicare patients can be classified as Medicare dependent hospitals (MDHs). Generally speaking, a MDH is located in a rural area, has 100 beds or less, is not classified as an SCH, and has at least 60 percent of acute inpatient days or discharges attributable to Medicare in the hospital cost reporting period that began during fiscal year 1987 or in two of the three most recently audited cost reporting periods for which there is a settled cost report. Originally intended to be a temporary classification status, Congress has extended the MDH designation several times. BBRA extended the sunset date for MDH classification to September 30, 2006.

The financial advantages of an MDH designation are less than those afforded to an SCH designation. An MDH can receive higher Medicare payments than other acute care hospitals in the same circumstances. Specifically, an MDH hospital will be paid based on its adjusted FY1982 or FY1987 hospital specific costs rather than the national base rate if that will result in higher payments. However, an MDH will receive only 50 percent of the difference between the base rate and its adjusted FY1982 or FY1987 hospital-specific costs. The other benefit is that an MDH, like an SCH, continues to be protected from a decrease of more than 5 percent in its total inpatient cases due to circumstances beyond its control.

Rural Referral Centers (RRCs)--RRCs are relatively large rural hospitals that generally provide a broad array of services and treat patients from a wide geographic area. These rural hospitals are thought to have operating costs more similar to urban hospitals than to the average smaller community hospitals, because of bed size, a large number of complicated cases, a high number of discharges, or a large number of referrals from other hospitals or from physicians outside the hospital's service area. Originally, only rural hospitals with 500 or more beds received special treatment as a referral center. Presently, RRCs must have at least 275 beds or meet specific criteria which indicate that the facility receives a high referral volume from other hospitals.

A rural hospital can qualify as a RRC if it meets the bed size criteria of 275 or more beds and meets the following referral standards and service area standards: at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the hospital's staff and at least 60 percent of its Medicare patients reside more than 25 miles from the hospital. Alternatively, a rural hospital must meet certain case-mix and discharge standards. Specifically, the hospital must have (1) a case-mix index equal to or greater than the national or regional median case mix index for all urban hospitals, excluding hospitals with approved teaching programs; and (2) at least 5,000 discharges per year (3,000 discharge for osteopathic hospitals) or at least the median number of discharges for urban hospitals in the same region. Under this alternative standard, a hospital must meet one of the following referral or service area standards: more than 50 percent

of the hospital's medical staff are specialists, at least 60 percent of its discharges are for inpatients who reside more than 25 miles from the hospital, or at least 40 percent of inpatients treated at the hospital have been referred either from physicians not on the hospital's staff or from other hospitals.

Under the original structure of IPPS, RRCs received the urban rather than the rural base payment rate. When the other urban and rural payment rates were equalized in FY1995, RRCs lost some of the benefit of their classification status. However, qualifying RRCs receive a higher DSH adjustment than do other rural hospitals. Also, as discussed subsequently, RRCs continue to be entitled to preferential consideration before the Medicare Geographic Classification Review Board. An RRC does not need to demonstrate proximity to an area or establish that its wages exceed 106 percent of the average wage in the area where it seeks to be redesignated.

Hospital Swing Beds--Small rural hospitals have had difficulty in establishing separately identifiable units for Medicare and Medicaid long-term care because of limitations in their physical plant and accounting capabilities. These hospitals had an excess of hospital beds and their communities had a scarcity of long-term care beds in Medicare and Medicaid participating facilities. Under the swing bed program started under OBRA 1980 (P.L. 96-499), certain rural hospitals with fewer than 50 beds were permitted to use their inpatient facilities, as necessary, to furnish long-term care services. OBRA 1987 extended the Medicare swing-bed program to rural hospitals with less than 100 beds with certain payment limitations. Prior to the skilled nursing facility (SNF) PPS described subsequently, hospitals with swing beds were paid the average Medicare rate per patient day for routine services provided in freestanding SNFs in their census region; ancillary services were reimbursed on a reasonable cost basis. Most swing bed providers have been paid using the SNF PPS, starting for cost reporting periods on or after July 1, 2002. Critical access hospitals (discussed subsequently) with swing beds are exempt from the SNF PPS. In 2002, there were 1,067 swing-bed hospitals certified to provide acute care or SNF services.

Critical Access Hospitals--BBA 1997 provided for the Rural Hospital Flexibility Program which created a new Medicare category of rural entities, critical access hospitals (CAHs), and authorized a companion grant program of $25 million annually for 5 years to establish networks for improving access to health care services in rural communities. Based on earlier demonstration programs of rural primary care hospitals and medical assistance facilities, CAHs provide emergency, outpatient and limited inpatient services in rural areas. Before a hospital can be designated as a CAH, the State must submit and have approved a rural health plan implementing the Medicare Rural Hospital Flexibility Program.

The original CAH provisions were subsequently modified. Currently, to qualify as a CAH, the rural, for-profit, nonprofit, or public hospital must be located more than 35 miles from another hospital or 15 miles in areas with mountainous terrain or those where only secondary roads are available. These milage standards may be waived if the hospital has been designated by the State as a necessary provider of health care. Under certain circumstances, hospitals that have closed

within the past 10 years may be designated as CAHs. All CAHs must provide 24-hour emergency services; and operate a limited number of inpatient beds in which hospital stays can average no more than 96 hours. Although CAHs are limited to 15 acute-care beds, these facilities may have an additional 10 swing beds that are set up for skilled nursing facility level care. While all 25 beds can be used as swing beds, only 15 of the 25 can be used for acute care at any time. Any bed of a unit of the facility that is licensed as a distinct-part SNF is not included in these bed counts. Generally, a rural hospital designated as a CAH receives reasonable, cost based reimbursement for care rendered to Medicare beneficiaries. 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 percent of the fee schedule payment for professional services. The reasonable cost of outpatient CAH services may include the reasonable compensation and related costs for an emergency room physician who is on call but not present on the premise of the CAH, if the physician is not otherwise furnishing physicians' services and is not on call at any other provider or facility. 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.

As of April 2003, 763 hospitals have been certified by CMS as CAHs; 442 of these CAHS have been governor-designated as necessary providers as opposed to meeting the Federally mandated mileage and location standards. More than half (51 percent) of all CAHs are located in 10 States; 3 States, Delaware, New Jersey, and Rhode Island, do not participate in the program. Sixty-nine additional hospitals have CAH designations that are pending.

Geographic Reclassification of Hospitals--Unlike other providers, acute hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for a change in classification from a rural area to an urban area, or reassignment from one urban area to another urban area. The MGCRB was created to determine whether a hospital should be redesignated to an area with which it has close proximity for purposes of using the other area's standardized amount, wage index, or both. If reclassification is granted, the new wage index will be used to calculate Medicare's payment for inpatient and outpatient services. Other services offered by the hospital such as rehabilitation services in a distinct part unit will be paid using the wage index from the hospital's original area. Hospital reclassifications are established on a budget neutral basis so aggregate IPPS payments will not increase as a result. A hospital may apply for reclassification individually, as a member of a group of hospitals, and as a member of a statewide wage index area; depending upon the type of application, different criteria apply.

Generally, for an individual hospital to qualify for reclassification, it must demonstrate a close proximity to the areas where they seek to be reclassified. This proximity can be established if one of two conditions is met: (1) an urban hospital must be no more than 15 miles and a rural hospital must be no more than 35 miles from the area where it wants to be reclassified; or (2) at least 50 percent of the hospital's employees reside in the area. A RRC or a SCH (or a hospital that is both

a RRC and a SCH) does not have to meet the proximity test. If qualified, it can be redesignated to the urban area that is closest to the hospital. If a rural area is closer, then the SCH or the RRC may seek reclassification to either the closest rural area or the closest urban area.

After establishing appropriate proximity, a hospital may qualify for the payment rate of another area if it proves that its incurred costs are comparable to those of hospitals in that area. To use an area's base payment, a hospital must demonstrate that its average case-mix adjusted cost per discharge is equal to or more than its current rate plus 75 percent of the difference between that rate and the rate it would receive if reclassified. To use an area's wage index, a hospital must demonstrate that its average hourly wage is equal to at least 82 percent (a rural hospital) or 84 percent (an urban hospital) of the average hourly wage of hospitals in the area to which it seeks redesignation. Also an urban hospital cannot be reclassified unless its average hourly wage is at least 108 percent of the average hourly wage of the area in which it is located; this standard is 106 percent for rural hospitals seeking reclassification to an area. An exception to these standards has been established for a dominating hospital that comprises at least 40 percent of the area's total wages.

For redesignations starting in FY2003, the average hourly wage comparisons used to determine whether a hospital can use another area's wage index are based on 3 years worth of lagged data submitted by hospitals as part of their cost report. For instance, FY2004 wage index reclassifications were based on weighted 3-year averages of average hourly wages using data from FY1998, FY1999, and FY2000 cost reports. Starting in FY2003, redesignations are for 3 years unless a hospital withdraws or terminates the redesignation.

There are some limitations on reassignment. Effective for FY2002 and subsequently, a hospital may not be reclassified for purposes of using another area's standardized amount if the area to which the hospital seeks reclassification does not have a higher standardized amount than that currently received by the hospital. A hospital that seeks reclassification for the purpose of using another area's wage index may apply for reclassification only to an area that has a higher pre-reclassified average hourly wage than that of the hospital's original geographic area. In addition, a hospital seeking reclassification for both wage index and base payments purposes may not be redesignated to more than one area. Under certain circumstances, all the hospitals in a rural county can be redesignated into an urban area; all the hospitals in an urban county can be redesignated into another urban area; and all the hospitals in the State can be redesignated and paid using a statewide wage index.

Certain rules have been established in statute and by regulation that specify the changes to an area's wage index value that occur when hospitals are reclassified by the MGCRB. For example, an MSA's wage index value is never lower than its State's rural wage index value. If a hospital reclassification causes the wage index in the new area to fall by 1 percent or less, the area's original wage index applies to these newly assigned hospitals (as well as to the original hospitals in the area). However, if reclassification causes the wage index value to fall by more than

1 percent, the area's wage index is recalculated (with the wage data from the redesignated hospitals) and the combined wage index value applies to redesignated hospitals; the wage index values for hospitals located in the area are not affected. In MSAs where the wage index value increases because of reclassification, all hospitals in the area (those that are physically located there and those that have been reassigned) use the higher wage index. Hospitals in areas whose wage index values would be reduced by excluding the wage data for hospitals that have be reclassified continue to have their wage indexes calculated as if no reclassification occurred. Hospitals in rural areas whose wage index values increase because of reclassification are allowed to benefit through recalculation.

Aside from reclassifications through the MGCRB, hospitals have also been reclassified by law. Specifically certain rural hospitals can reclassify as urban if the county in which the hospital is located is adjacent to two or more MSAs and meets criteria regarding commuting patterns of its residents to the central counties of the adjacent MSAs. BBRA 1999 provided for an update of the standards used for the geographic reclassification of these "rural deemed urban" hospitals. BBRA 1999 also provided that certain urban hospitals could be reclassified as rural hospitals if the hospital is located in a rural census tract of an MSA (as determined under the most recent Goldsmith Modification); is located in an area designated by State law or regulation as a rural area; or the hospital would qualify as a referral center or as an SCH if the hospital were located in a rural area; or the hospital meets other criteria as specified by the Secretary. Finally, BBRA 1999 established that certain counties should be considered as part of specified urban areas for the purposes of Medicare inpatient reimbursement.

SPECIALITY HOSPITALS AND DISTINCT PART UNITS

Certain facilities were excluded from IPPS when it was implemented in 1984 because the DRGs were thought not to adequately represent their patients' resource needs or the volume of Medicare patients was deemed to be insufficient so that payments based on averages and made on a per discharge basis would be inadequate. The excluded providers include rehabilitation, long-term care, psychiatric, children's, and cancer hospitals, rehabilitation and psychiatric hospital distinct part units, religious nonmedical heath care institutions, and hospitals located outside the 50 States and Puerto Rico. Hospitals in certain States have been excluded from IPPS and operate under a State hospital reimbursement control system approved by the Secretary under Section 1886(c) of the Social Security Act (as added by Tax Equity and Fiscal Responsibility Act of 1982 or TEFRA and subsequently modified). At this point, only hospitals in Maryland are paid according to a State reimbursement control system.

This section will primarily discuss the payment systems for those specialty hospitals and units that have been excluded from IPPS and paid on the basis of reasonable costs subject to the TEFRA limits: cancer hospitals; children's hospitals; psychiatric hospitals and units; rehabilitation hospitals and units; and long-term care hospitals. Certain of these facilities are currently paid under

different, recently implemented provider-specific prospective payment systems. Inpatient rehabilitation facilities (IRFs) began to be reimbursed under a PPS in January 2002; long-term care hospitals (LTCHs) began to be reimbursed under a PPS in October, 2002. The section will begin with brief background information on the TEFRA payment system still used to pay cancer, children's, and psychiatric hospitals and units, followed by descriptions of the IRF-PPS and LTCH-PPS.

Cancer Hospitals, Children's Hospitals, and Psychiatric Hospitals and Units

In order to qualify for exemption from IPPS, a psychiatric hospital or distinct part unit must be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of persons with mental illness as well as meet the conditions of participation for hospitals and the special conditions of participation for psychiatric hospitals. A distinct part psychiatric unit must meet the requirements established for distinct part units in hospitals including separately identifiable admission and discharge records, physically separate beds and must also meet additional requirements established in regulation. Eleven cancer hospitals are currently exempt from IPPS. These hospitals generally are 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 an acute general hospital or university-based medical center); and have at least 50 percent of its discharges with a diagnosis of neoplastic disease. Eighty-one children's hospitals are currently exempt from IPPS. These hospitals are those engaged in furnishing services to inpatients who are predominantly individuals under the age of 18.

Essentially, under TEFRA rate of increase limits, a specialty hospital is paid on a reasonable cost basis subject to the rate of increase ceiling. A TEFRA hospital is paid the lower of its actual operating costs or a facility-specific target amount and will receive additional payments depending upon the relationship of its cost per discharge to its target amount. Generally, a provider with costs under its target will be rewarded with a bonus payment; a provider with costs per discharge above its target will receive a relief payment. A provider's target amount is based on its Medicare allowable costs per discharge in a base year, updated to the current year by an annual update factor. In FY2004, the update is the increase in the MB for excluded hospital which is 3.4 percent. Medicare pays the capital costs in these providers on a reasonable cost basis.

Generally, new providers have had significantly higher costs (and subsequently higher target amounts) than older, established providers. In an effort to reduce disparities, BBA 1997 modified the way in which bonus and relief payments are calculated. Also, facilities and exempt units that were excluded from IPPS before FY1991 were permitted to update (or rebase) their target amount for FY1998 and beyond. New providers that are exempt from IPPS (those that receive payments for the first time on or after October 1, 1997) will receive the lesser of their operating costs or 110 percent of the national median of the updated, locality adjusted target amount for similarly situated hospitals for each of its first two cost reporting periods for which it has a settled cost report. This payment option for

new providers now applies only to new psychiatric hospitals and units.

Inpatient Rehabilitation Facilities and Distinct Part Units

An inpatient rehabilitation facility (IRF), both freestanding IRFs and distinct part rehabilitation units of acute hospitals, must meet certain requirements to be excluded from IPPS and paid as an IRF. At least 75 percent of a facility's inpatient population must require intensive rehabilitation services for one of 10 conditions including treatment of stoke, spinal cord injury, major multiple trauma, brain injury, polyarthritis, and other specific conditions. Also a rehabilitation unit must have beds that are physically separate from the hospital's other beds, separately identified admission and discharge records from those of the hospital, and policies that specify that necessary clinical information is sent to the unit upon transfer of a hospital's patient to the unit.

Simply stated, under PPS, Medicare pays an IRF a predetermined, fixed amount per discharge, depending upon a patient's impairment level, functional status, comorbid conditions and age. Certain adjustments are made for facility level characteristics to account for area wage variations, rural location and the percentage of low-income patients (LIPs) served. IRF-PPS also includes case level adjustments. Specifically, reduced or additional amounts are paid for early transfers, short-stay outliers, patients who die before transfer and patients who are extraordinarily costly (outliers). These payments encompass inpatient operating and capital costs of furnishing covered rehabilitation services, but not the costs of approved educational activities, Medicare bad debts and other services that are paid outside of the IRF-PPS. Medicare's PPS payment to an IRF for any patient will depend upon a clinician's comprehensive assessment of that patient upon admission and again at discharge. These documented assessments must be based on the direct observation of and communication with the patient; information may be supplemented with information from other sources, including family members or other clinicians. The prescribed patient assessment instrument (PAI) form, the Uniform Data Set for Medical Rehabilitation (UDSmr), encompasses about 55 questions used to ascertain a patient's functional independence including motor skills and cognitive capacities and to establish a patient's comorbidities. A patient's assessments (from both admission and discharge) are transmitted to CMS electronically once and at the same time. Failure to meet the IRF PAI transmission deadlines results in a 25 percent reduction in Medicare's payment in all but extraordinary circumstances.

Using data from the patient's initial assessment, each Medicare patient is classified into one of 100 mutually exclusive case-mix groups (CMGs). First, a patient is placed into one of 21 rehabilitation impairment categories (RICs) that encompass clinically similar conditions, such as stroke or traumatic brain injury, as the primary cause of admission. Next, a patient is placed into a CMG within the RIC; the CMG assignment depends upon the patient's functional status and, in some instances, age. Within a CMG, a patient is assigned to one of 4 categories or comorbidity tiers using clinical information from the patient's discharge assessment. The presence of comorbidities was found to substantially increase the

average cost of a specific CMG. Patients with the most serious conditions are assigned to tier 1; patients with the least serious conditions are assigned to tier 3; those without any relevant comorbidities are assigned to the "none" tier. 95 CMGs encompass the 21 RICs; 5 other CMGs have been established for patients with special circumstances; one of the 5 CMGs is for patients with very short stays and the 4 remaining are for patients who die before treatment is completed. Each of these 5 special CMGs have only one payment rate and no comorbidity tiers.

CMS established relative or cost weights using cost report data from FY1996, FY1997, and FY1998 and charge data from calendar year (CY) 1999. The relative weights account for a patient's resource needs for each of the CMGs and payment tiers; 385 relative weights are used to determine Medicare payment rates. Unlike those used in IPPS, these relative weights are not updated annually. Within any given CMG, the cost weight for a patient with a high comorbidity is greater than the cost weights for those patients with low or no comorbidities. This cost weight is multiplied by a standardized payment conversion factor (also referred to as the budget neutral conversion factor) to calculate the payment for a given patient.[4] The standard payment amount was originally constructed using the facility-specific information from 508 facilities, including cost reports from FY1995, FY1996, and FY1997; applicable target amounts, as well as Medicare claims (including corresponding UDSmr data) from CY1996 and CY1997. CMS estimated payments that would have been made under the prior payment system; calculated the average weighted payment per discharge under the IRF-PPS, and determined a budget neutral conversion factor. This payment amount was then subject to a behavioral offset of 1.16 percent to account for coding improvements and patient discharges that would occur earlier in the IRF stay. In FY2004, the standard payment amount is $12,525.

For FY2004 IRF-PPS payments, CMS uses FY1999 acute care hospital wage data (used in the FY2003 IPPS but with no accounting for geographic assignments) to compute the IRF wage index values. The labor-related portion (72.395 percent) of the Federal payment rate is multiplied by the IPPS wage index value for the IRF's area (either MSA or rural area). This wage-adjusted amount is added to the non-labor related portion of the rate to determine the wage-adjusted Federal payment rate. IRFs in rural areas receive an additional 19.14 percent increase to the Federal payment rate. An additional payment is made to IRFs that serve low-income patients (LIPs). The same measure, the percentage of poor Medicare and Medicaid days in a given facility, that is used to establish DSH payments for most IPPS hospitals is used as the measure for LIPs served in an IRF. In the IRF-PPS, the additional payments are calculated using a logarithmic formula where the LIP measure is raised to the power of .4839. An IRF will receive additional payments if it serves at least one low-income patient.

[4] BBA 1997 specified that budget neutral payments were to be established under IRF-PPS during FY2001 and FY2002 that would result in the amount of total payments equal to 98 percent of the operating and capital payments that would have been made had IRF-PPS not been enacted. BIPA increased the amount of the IRF-PPS budget neutral payments to 100 percent in FY2002. Unlike the PPS for long-term care hospitals discussed subsequently, the IRF-PPS budget neutrality provision is no longer mandated.

Table 2-18 shows the IRF-PPS adjusted payment calculation for CMG 0112 (without comorbidities) in 2 different facilities. CMG 0112 is used to establish Medicare payments for stroke patients from 82 to 88 years old who have motor scores that range from 12 and 26 (without comorbidities). It has a relative weight of 2.0015; Medicare's Federal prospective payment rate for this CMG is $25,068.79 ($12,525*2.0015=$25,068.79). This represents the Federal rate before the relevant facility-level adjustments are applied. IRF-PPS payments will be adjusted to account for a facility's relative area wage, rural location, and low-income percentage. In FY2004 a facility in rural Alabama has a wage index value of 0.7660 and one in the Oakland, CA MSA has a wage index value of 1.5072. Both facilities have a 26 percent DSH percentage which qualifies them for a LIP adjustment of 11.82 percent.

TABLE 2-18—EXAMPLE OF IRF-PPS PAYMENT CALCULATION FOR CMG 0112 (FOR CERTAIN STROKE PATIENTS WITHOUT COMORBIDITIES) INCLUDING FACILITY LEVEL ADJUSTMENTS, FISCAL YEAR 2004

Component	IRF in rural Alabama	IRF in Oakland, CA MSA
Federal prospective payment rate for CMG 0112	$25,068.79	$25,068.79
Labor portion of Federal payment ($25,068.79 *0.72526)	$18,181.39	$18,181.39
Wage index for IRF	0.7660	1.5072
Wage-adjusted amount	$13,926.94	$27,402.99
Nonlabor related amount $25,068.79*0.27474)	$6,887.40	$6,887.40
Wage-adjusted Federal payment	$20,814.34	$34,290.39
Rural adjustment	1.1914	1.0
Subtotal	$24,798.21	$34,290.39
LIP adjustment	1.1182	1.1182
Total FY2004 adjusted Federal prospective payment for CMG 0112	$27,729.36	$38,343.51

Source: CRS calculation based on information in FY2004 IRF-PPS published in the *Federal Register* on August 1, 2003.

In addition to facility level adjustments, an IRF may receive additional or reduced Medicare payment for any given case, depending upon the Medicare patient's circumstances. Additional payments are made for cases that are high cost outliers. A patient will be considered to be an outlier if the estimated cost of the case exceeds an adjusted threshold amount. This cost is calculated by multiplying the charge by the facility's overall cost-to-charge ratio obtained from the latest settled or tentatively settled cost report.[5] An IRF will receive 80 percent of the difference between the estimated cost of the case and the outlier threshold. In this instance, the threshold amount is the sum of the facility level CMG payment and the threshold amount multiplied by those facility level adjustments. For FY2004,

[5] If a facility's cost to charge ratio is 3 standard deviations above the applicable national average cost to charge ratio, then a ceiling on this ratio is imposed. Separate calculations and ceilings apply to rural and urban IRFs.

the unadjusted threshold amount is $11,211, which CMS estimates will result in total estimated outlier payments of approximately 3 percent of total IRF-PPS payments.

Medicare pays a reduced amount for a patient who is an early transfer. The patient has a length of stay that is greater than 3 days but less than the average for the assigned CMG and is transferred to another rehabilitation facility (which has been defined as a rehabilitation facility, a long-term care hospital, a short-term hospital, or a nursing home.) No payment reduction applies for patients who are discharged to a home health agency or other outpatient therapy setting. Also, the IRF will receive the full amount if the transfer occurs after the patient has been treated for the average length of stay associated with the CMG. The payment rate for early transfers is based on the per diem payment for the applicable CMG (to which the patient has been assigned). The IRF will receive an additional one half-day payment to recognize the higher costs generally associated with the patient's first day of care. The early transfer payment would include any facility level payment adjustments.

Medicare pays for short-stay outliers using one of the 5 special CMGs. These are patients who are not transfers, but are discharged from the facility after being hospitalized no more than 3 days. These short-stay outliers may occur because the patient could not tolerate a full course of intensive inpatient rehabilitation treatment, left against medical advice, or died within 3 days of admission. Also, patients who are discharged from and return to the same IRF by midnight of the 3rd consecutive calendar day are considered interrupted stays. Medicare makes only one IRF-PPS payment for these cases. In addition to PPS payments, Medicare will pay IRFs for certain items such as Medicare beneficiaries' bad debts, the costs of approved educational programs and for blood clotting factors provided to Medicare inpatients who have hemophilia outside of the PPS.

Each year the IRF-PPS standardized payment amount in increased based on the modified MB for excluded hospitals (those not paid under IPPS). This MB is based on cost report data from Medicare participating inpatient rehabilitation and psychiatric facilities as well as long-term, children's and cancer hospitals which were subject to TEFRA payment limitations. The TEFRA MB only includes operating costs, so the IRF-PPS update is based on a modified TEFRA MB that reflects capital costs. CMS revised and rebased the MB with capital for excluded hospitals to incorporate 1997 cost report data starting in FY2004. The new MB includes an explicit cost category for blood and blood products. Also, the calculation of this modified MB with capital is based on a ratio of operating to capital costs where operating costs account for 91.032 percent of the total costs and capital costs account for the remaining 8.968 percent of the total costs.

Long-Term Care Hospitals

Long-term care hospitals (LTCHs) are designed to provide extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions. Most patients in LTCHs have several diagnosis codes on their Medicare claims. Approximately one-half of the patients

have five or more diagnoses on their claims. LTCHs consist of a relatively heterogeneous group of providers that typically provide a range of services, including comprehensive rehabilitation, head trauma treatment, and pain management. Although some LTCHs treat a wide range of conditions, others specialize in one or two types of conditions. The country's oldest LTCHs evolved from tuberculosis and chronic disease hospitals and may now still focus on patients with chronic conditions. The newer facilities are designed primarily to care for ventilator dependent patients. Finally LTCHs are distributed unevenly across the United States; one third of the facilities are located in Massachusetts, Texas, and Louisiana. Old LTCHs (those participating in Medicare when IPPS was implemented) are generally located in the northeastern region of the United States, while new LTCHs are typically located in the southern region. Old LTCHs are either government controlled or nonprofit. In contrast, one half of the LTCHs that began participation in Medicare between 1983 and 1993 and two-thirds of those that began participation in Medicare in FY1994 or later are proprietary facilities.[6] In recent years, the LTCH group has evolved to include hospitals-within-hospitals (or co-located hospitals) and satellite facilities in addition to traditional freestanding facilities. The best available information indicates that as of 1997, roughly 21 percent of the LTCHs were co-located hospitals and 68 percent were freestanding; the affiliation status of the remaining 11 percent could not be identified.[7] The number of LTCHs participating in Medicare has significantly increased. In 1991, there were 91 LTCHs, a number that increased to 155 in 1994, 225 in 1999, 252 in 2000, and 297 in April 2003.

LTCHs are certified under Medicare as short-term acute care hospitals which have been excluded from IPPS. An LTCH has a Medicare inpatient average length of stay (ALOS) greater than 25 days or an ALOS for all patients of greater than 20 days if the hospital meets certain requirements. Both covered and noncovered medically necessary days for Medicare patients are included in the 25-day ALOS calculation. Although, by statute, there are no LTCH distinct part units, there are satellite and hospital-within-a-hospital LTCHs that are co-located or share the same campus with acute care hospitals and other Medicare providers. To be exempt from IPPS, a hospital-within-a-hospital must have a separate governing body, chief executive officer, chief medical officer, and medical staff and meet one of the following criteria: (1) perform basic functions independently from the host hospital; (2) incur no more than 15 percent of its total inpatient operating costs for items and services supplied by the hospital in which it is located; or (3) have at least 75 percent of its patients admitted from sources other than the host hospital. A satellite provider is a hospital-within-a-hospital facility that is owned by a separate, existing LTCH and is subject to distinct criteria established by regulation. Different payment rules can apply to these co-located Medicare providers, depending on the number and percentage of Medicare discharges and readmissions between the entities.

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[6] *Federal Register*, vol. 67, no. 56, March 22, 2002, p. 13424.

[7] "Long-Term Care Hospitals Under Medicare: Facility Level Characteristics, Korbin Liu et al, *Health Care Financing Review*, Winter 2001. vol. 23, no 2., p. 6

Effective for the first cost reporting period beginning on or after October 1, 2002, LTCHs are paid under a PPS, subject to a 5-year transition period. During the transition period, a facility's percentage payment based on the Federal rate increases by increments of 20 percentage points over the 5 year period. For instance, in the first year of its transition period, a LTCH was paid on a blended rate based on 20 percent of the Federal rate and 80 percent of its TEFRA target amount; the transition blend is based on 40 percent of the Federal rate and 60 percent of its TEFRA target amount in the second year. By cost reporting periods beginning or after October 1, 2006, the transition period will be complete. Alternatively, a LTCH may elect the one time option to be paid based on 100 percent of the Federal prospective rate. Also, any new LTCH must be paid on 100 percent of the Federal rate.

Under this PPS, Medicare pays a LTCH a predetermined amount per discharge, depending upon the patient's assignment into one of 510 LTC-DRGs. The patient classification system, LTC-DRGs, is based on IPPS DRGs that are reweighted to reflect the resource use of longer stay patients. Only one LTC-DRG is assigned to a hospitalization at the patient's discharge. The LTCH-PPS includes several facility level adjustments such as the area wage index and a cost of living adjustment (COLA) of up to 25 percent for LTCHs in Alaska and Hawaii, but it does not include adjustments for rural location, low income patients served, or IME. With respect to case level adjustments, the LTCH-PPS will pay reduced amounts for short-stay outliers (but not cases that are deemed to be interrupted stays) and additional amounts for high cost outliers. Unlike the IRF-PPS, there are no special payment policies for transfer cases or deaths. The LTCH-PPS payment encompasses payments for both operating and capital-related costs of inpatient care, but certain costs, including those associated with approved educational programs, Medicare's bad debt expenses, or blood clotting factors, are paid for separately. Starting July 1, 2003, CMS changed the LTCH-PPS from the Federal fiscal year (from October 1 through September 30) to a rate year that begins July 1 through June 30, of each year. This date change affects the timing of the annual issuance of the LTCH update, Federal rate, and applicable facility and case level payment adjustments such as revisions to the wage index values and the fixed loss amount or high cost outlier threshold. Changes to the LTC-DRGs classifications and their relative weights will remain on a Federal fiscal year schedule as will the effective dates for the LTCH-PPS transition blend period.

CMS has adapted the IPPS patient classification system to better reflect the resource use and patient load in LTCHs. Because LTCHs often specialize in certain types of cases, such as ventilator dependent patients, CMS uses a hospital-specific relative value method to calculate the relative weights for LTC-DRGs that differs from the method used to calculate the IPPS DRG relative weights. Generally, the charges associated with a given LTC-DRG at each facility are adjusted to remove the effect of its pricing strategy (the facility's average markup in charges) and patient intensity (the facility's case mix index). In calculating these relative weights, statistical outliers and cases with a length of stay of 7 days or less are removed. Weights also are adjusted for cases where the LTCH stay is less than

five-sixths of the geometric average length of stay. Unlike IPPS, low volume LTC-DRGs, (those with less than 25 cases) are used to construct LTC-DRG weights. The 161 low volume LTC-DRGs are grouped into 5 quintiles based on average charge per discharge. CMS calculates a relative weight and average length of stay for these quintiles using the same formula as the regular LTC-DRGs; those values are then assigned to each of the low volume LTC-DRGs that are included in the quintile. CMS identified 159 of the 510 LTC-DRGs with no LTCH cases in the FY2001 claims data used to establish the cost weights. These no volume LTC-DRGs are crosswalked to other clinically similar LTC-DRGs and then grouped into the most appropriate of the 5 quintiles established for low volume LTC-DRGs. CMS made other adjustments to certain paired LTC-DRGs to correct for incompletely coded claims.[8] Finally, LTC-DRGs representing organ transplants were given a 0.00 cost weight, since none of the currently participating LTCHs are Medicare-approved transplant centers (or apparently, have ever expressed any interest in becoming such providers.)

The cost weight for a LTC-DRG multiplied by a standard Federal rate represents the framework for Medicare's payment for a given patient which, as mentioned earlier, is then subject to facility level and case level payment adjustments. CMS used cost report data from FY1996 through FY1999 and FY2001 claims data, updated to FY2003, to calculate the LTCH standard Federal payment rate. Data from certain providers that did not maintain charge data (providers that billed using an all inclusive rate) or that operated under demonstration projects were excluded. CMS adjusts the standard Federal rate by a reduction factor of 8 percent as an offset for the estimated LTCH outlier payments. By statute, total payments under LTCH-PPS must be equal to the amount that would have been paid if the PPS had not been implemented. Accordingly, CMS included a 0.34 percent reduction in the Federal rate to account for behavioral changes that would occur as LTCH respond to incentives inherent in the new payment system. CMS includes a budget neutrality offset to account for the increased spending that results from LTCHs electing full Federal payment during the transition period. The amount of the offset is re-estimated each year. In FY2003, CMS imposed a 6.6 percent budget neutrality offset (using a factor of 0.934 which is 1.0 minus .066) to account for $50 million in projected additional costs that would occur that year because of the number of LTCH that CMS anticipated would elect payment based on the Federal rate. In the 2004 rate year, the budget neutrality offset was established at 6 percent to account for the $120 million in additional payments attributed to the LTCH-PPS transition period. The budget offset applies to all LTCH payments, not just those computed using the full Federal payment during the transition period; a LTCH that is being paid on a transition blend with some proportion of its payments based on its TEFRA rate would have its TEFRA based payments reduced as well. Finally, CMS will review LTCH payments and may make a one-time prospective adjustment to the LTCH

[8] Under TEFRA reimbursement, Medicare payments to a LTCH were not affected by the diagnosis and procedure codes included on a patient's claim. CMS anticipates that this data from LTCHs will improve substantially, given the payment incentives under LTCH PPS.

PPS by October 1, 2006, to correct for any errors in the original budget neutrality calculations.

Like the IRF-PPS, the LTCH-PPS uses the IPPS wage index data for its adjustment. However, because CMS did not find a significant relationship between LTCHs' costs and their geographic location, the LTCH wage index adjustment is being phased in using 20 percentage point increments each year over a 5-year period, starting with cost reporting periods beginning on or after October 1, 2002. The timing of the implementation of the wage index adjustment is linked to the provider's actual cost reporting period. Annual updates to the wage index, however, are linked to the LTCH rate year. Consequently, the wage adjustment for a particular LTCH may change during its cost reporting period. For instance, a LTCH with a cost reporting period from January 1, 2003 through December 31, 2003 is paid using 1/5th of the applicable wage index value for that entire cost reporting period. From January 1, 2003 to June 30, 2003, its payments will be based on 1/5th of the FY2002 IPPS wage index value for its area; from July 1, 2003 to December 1, 2003, its payments will be based on 1/5th of the FY2003 IPPS wage index value for its area. Starting January 1, 2004, it will receive 2/5ths of the FY2003 IPPS wage index value.

To illustrate this wage adjustment, assume the LTCH with a cost reporting period beginning on January 1 is located in the Chicago, MSA. This MSA has an FY2002 IPPS wage index value of 1.1008, so the LTCH would receive a wage index adjustment of 1.0202 starting CY2003, the first year of its phase-in period. It would receive this wage index adjustment until June 30, 2003. Starting for discharges on July 1, 2003, all LTCHs will be paid using the FY2003 IPPS wage index values (with no accounting for geographic reclassifications); the applicable FY2003 wage index value for the Chicago MSA is 1.15. The LTCH would receive a wage index adjustment of 1.0209 for discharges from July 1, 2003 to December 31, 2003 (1/5th of 1.1044) when it is still in its first year of the wage index phase-in period. Starting in CY2004, the LTCH will be paid using 2/5ths of the applicable wage index value. The LTCH would receive a wage index adjustment of 1.0418 (2/5ths of 1.15) starting on January 1, 2004 for the next 6 months; this adjustment would change on July 1, 2004 when the LTCH wage index would be updated.

CMS has established the Federal rate of $35,726 for the 2004 LTCH-PPS rate year. The labor-related portion (72.885 percent) of the Federal payment rate is multiplied by the applicable area's wage index value of the physical location of the LTCH. This wage-adjusted amount is added to the non-labor related portion of the rate which will be adjusted for COLA if applicable to determine the adjusted Federal payment rate. Table 2-19 illustrates the LTCH-PPS adjusted payment calculation for the LTCH in Chicago discussed earlier and a case in LTCH-DRG 09, Spinal Disorders and Injuries, which has a relative weight of 1.4118. This particular LTCH has opted for payment based on 100 percent of the Federal rate. As mentioned earlier, the budget offset would apply equally to LTCH that is being paid on a transition blend; its TEFRA based payments would be reduced as well.

TABLE 2-19—EXAMPLE OF LTCH-PPS PAYMENT CALCULATION, WITH FACILITY LEVEL ADJUSTMENTS, FOR DISCHARGE STARTING JULY 1, 2003

Component	LTCH in the Chicago MSA
Federal prospective payment rate	$35,726
Labor portion of Federal payment ($35,726 *0.72885)	$26,038.90
1/5th the wage index for Chicago MSA	1.0209
Wage-adjusted amount	$26,583.11
Nonlabor related amount ($35,726*0.27474)	$9,687.10
Cost of living (COLA) adjustment	1.0
LTCH's wage-adjusted Federal rate for FY2004 ($26,583.11+$9,687.10)	$36,270.21
Relative weight for LTC-DRG 09, Spinal Disorders and Injuries	1.4118
Total adjusted Federal payment	$51,206.28
Budget neutrality offset	0.940
LTCH's FY2004 adjusted Federal prospective payment for LTC-DRG 09	$48,133.91

Source: CRS calculation based on FY2004 LTCH PPS information in published in the *Federal Register* on June 6, 2003.

Aside from facility level adjustments, the LTCH-PPS includes certain case level adjustments as well. Generally, a short-stay outlier will be paid the lesser of 120 percent of the cost of the case, 120 percent of the LTC-DRG specific per diem payment, or the full LTC-DRG payment. In this PPS, a short-stay outlier is a case that has a length of stay less than or equal to 5/6s of the ALOS for the LTC-DRG to which the case is assigned. For example, if the ALOS for a particular LTC-DRG is 30 days, then the short-stay outlier policy would apply to any stays that are 25 days or less in length (5/6s of 30 days is 25 days).

An interrupted stay is a case where a LTCH patient is discharged and then admitted directly to an inpatient acute care hospital, an IRF, a skilled nursing facility, or a swing-bed and then returns to the same LTCH within a fixed period of time which varies by provider type. The limit is 9 days or less in an acute hospital; 27 days or less in an IRF; 45 days or less in an SNF or in a swing-bed. If the patient returns to the LTCH within these fixed limits, Medicare treats the case as an interrupted stay and only one payment to the LTCH is made.

Finally, Medicare pays additional amounts for cases that are high cost outliers where the estimated cost of the case exceeds the outlier threshold. This threshold is the LTC-DRG payment plus a fixed-loss amount. CMS establishes the fixed loss amount annually so that projected outlier payments equal 8 percent of estimated total LTCH-PPS payments. The fixed-loss amount for the 2004 rate year is $19,590. CMS will pay 80 percent of cost above the outlier threshold for high cost outlier cases.

Like the IRF-PPS, the LTCH-PPS Federal payment rate is increased annually based on most recent estimate of the modified TEFRA MB for excluded hospitals (those not paid under IPPS) adjusted for capital costs. CMS revised and rebased the excluded hospital with capital MB to a 1997 base year and included an explicit cost category for blood and blood products. As mentioned earlier, the

calculation of this modified MB with capital reflects a ratio of operating-to-capital costs where operating costs comprise 91.032 percent of the total costs and capital costs account for the remaining 8.968 percent of total costs. Starting July 1, 2003, CMS changed the annual update to the LTCH Federal payment rate from the Federal fiscal year (from October 1 through September 30) to a rate year that begins July 1 through June 30, of each year. The 2004 update calculation included an adjustment for the change in the update cycle. The full 12-month MB with capital increase was estimated to be 3.3 percent which was reduced by -0.8 percent; the 2004 LTCH PPS rate year increase was 2.5 percent.

SKILLED NURSING FACILITY SERVICES

Coverage

Medicare covers extended care services provided in nursing homes for beneficiaries who require additional skilled nursing care and rehabilitation services following a hospitalization. These extended care services, commonly known as skilled nursing facility (SNF) benefits, are covered under Part A for up to 100 days per spell of illness and must be provided in an SNF certified to participate in Medicare. A spell of illness is that period which begins when a beneficiary is furnished inpatient hospital or SNF care and ends when the beneficiary has been neither an inpatient of a hospital nor an SNF for 60 consecutive days. A beneficiary may have more than one spell of illness per year.

In order to be eligible for SNF care, the beneficiary must have been an inpatient of a hospital for at least 3 consecutive days and must be transferred to an SNF, usually within 30 days of discharge from the hospital. Furthermore, a physician must certify that the beneficiary is in need of skilled nursing care or other skilled rehabilitation services on a daily basis, which, as a practical matter, can only be provided on an inpatient basis and which are related to the condition for which the beneficiary was hospitalized.

Payment

Prior to a congressionally mandated prospective payment system, Medicare paid for SNF care on a retrospective cost-based basis. This meant that SNFs were paid for the reasonable costs (as defined by the program) they incurred for the care they provided as determined at the end of the SNF's fiscal year. SNFs had few incentives to maximize efficiency and minimize their costs, and little inducement to control the amount or number of services they provided.

Prospective payment system--In BBA 1997, Congress required that a prospective payment system (PPS) for SNF care be phased in over 3 years, beginning with the SNF's first cost reporting period after July 1, 1998. SNF prospective payment involves grouping patients according to the type and intensity of services they require and setting a daily payment rate for each payment group. Like other PPSs that pay health care providers for care to Medicare beneficiaries on the basis of predetermined, fixed amounts, Medicare payments to SNFs are intended to pay the provider for its Medicare beneficiary costs on average. That is,

although the payment is a predetermined daily rate, a facility's actual costs may be above or below that amount for an individual patient. The incentive facilities have is to manage costs so that, on average, costs do not exceed the PPS average amounts. SNFs that provide the services at lower costs than the Medicare payment are able to keep the difference.

Unit of Payment--Under SNF PPS, a SNF receives a daily payment that covers all the services provided to the beneficiary that day including room and board, nursing, therapy, food, and medicine with very limited exceptions. Some care costs are paid separately under the statute such as physician visits and dialysis services. The daily base payment, called the “Federal per-diem rate,” is based on actual 1995 SNF costs that have been trended forward for inflation and varies by the urban or rural location of the SNF. The Federal per-diem rate is broken down into four components, two of which are adjusted for case mix: nursing component–adjusted for case-mix; therapy component–adjusted for case mix; therapy component–not adjusted for case mix; and the non-case mix adjusted component.

Case-Mix System--The statute requires the Secretary to develop an appropriate adjustment to the Federal rate to account for case mix. The case mix system developed adjusts the Federal per-diem rate for treatment and care needs of the beneficiary and is called Resource Utilization Groups, version III (RUG-III). RUG-III is composed of 7 major categories that are further differentiated into 44 specific patient groupings. The 7 major categories are “hierarchical,” that is, patients are automatically grouped into the highest paying groups given their condition. The 7 categories, in hierarchical order, are: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Function (see Table 2-20.) Patients in need of rehabilitative therapy services are automatically assigned one of the 14 rehabilitation groups, depending upon the minutes of rehabilitative services they receive in a week, the combinations of disciplines providing the services, and the patient’s activities of daily living (ADL) scores (ADL scores measure patients’ abilities in toileting, grooming, dressing and so forth). The next category, Extensive Services, is composed of 3 groups which use services requiring more technical knowledge and skill as the variables for patient assignment, rather than ADL scores. The third category, Special Care, is made up of 3 groups composed of patients with one or more of the conditions in this category. ADL scores determine group assignment within this category. The fourth category, Clinically Complex, is composed of 6 groups comprising patients with a variety of conditions including burns, septicemia and pneumonia or who require more complex care. ADL scores and patient depression determine group assignment within this category. The fifth category is Impaired Cognition, which is comprised of 4 groups of patients with poor cognitive performance. Patients receiving care that falls within this category are unlikely to qualify for Medicare coverage of their stay because of the skilled care requirements. The sixth category is Behavior Only, which has 4 groups. Patients receiving care that falls in this category have exhibited behaviors that include resisting care, being combative or who have hallucinations or delusions.

These patients are unlikely to qualify for Medicare coverage of their stay because they may not require skilled care. The final RUG category is Physical Function Reduced which contains 10 groups. Patients in this category are those who do not have any of the conditions or characteristics for the other groups. As with the earlier two RUGs, patients in this group are unlikely to require the skilled care needed to qualify for Medicare payment.

TABLE 2-20--RESOURCE UTILIZATION GROUPS (RUGS) CATEGORIES AND PAYMENT ADD-ONS

Service Category	Clinical condition/ service need		RUG-III Groups	Payment Add-on (in percent)
REHABILITATION – Patients requiring any combination of therapy services, based on the number of minutes of therapy received each week.	Ultra high: 720 or more minutes of therapy services per week, at least 2 therapy disciplines and 1 at least 5 days a week.	Patients with an ADL score of 16-18	RUC	6.7
		Patients with an ADL score of 9-15	RUB	
		Patients with an ADL score of 4-8	RUA	
	Very high: 500 to 719 minutes of therapy services per week, 1 discipline at least 5 days a week.	Patients with an ADL score of 16-18	RVC	6.7
		Patients with an ADL score of 9-15	RVB	
		Patients with an ADL score of 4-8	RVA	
	High: 325 to 499 minutes of therapy services per week, 1 discipline at least 5 days a week.	Patients with an ADL score of 16-18	RHC	6.7
		Patients with an ADL score of 9-15	RHB	
		Patients with an ADL score of 4-8	RHA	
	Medium: 150 to 324 minutes of therapy services per week, 5 days across 3 disciplines.	Patients with an ADL score of 16-18	RMC	6.7
		Patients with an ADL score of 9-15	RMB	
		Patients with an ADL score of 4-8	RMA	

TABLE 2-20--RESOURCE UTILIZATION GROUPS (RUGS) CATEGORIES AND PAYMENT ADD-ONS-continued

Service Category	Clinical condition/ service need		RUG-III Groups	Payment Add-on (in percent)
	Low: 45 to 149 minutes of therapy services per week over at least 3 days. Nursing rehabilitation 6 days per week, 2 activities.	Patients with an ADL score of 14-18	RLB	6.7
		Patients with an ADL score of 4-13	RLA	
EXTENSIVE SERVICES – Patients with an ADL score of at least 7 and who require other specified extensive services	Patient has required intravenous (IV) feeding in the last 7 days.		SE3	20
	Patient has required IV feeding in the last 14 days, IV medications, or suctioning.		SE2	20
	Patient has required tracheotomy care or are on a ventilator/respirator.		SE1	20
SPECIAL CARE – Patients with multiple sclerosis, quadriplegia, or cerebral palsy; who are tube fed and with aphasia, or who require radiation treatment, or who require treatment for surgical wounds, lesions, or ulcers (2 sites any stage or 1 site stage 2 or 3); or who have fever and dehydration, pneumonia, vomiting, or weight loss; or who require tube feeding	Patients with an ADL score of 17-18.		SSC	20
	Patients with an ADL score of 15-16.		SSB	20
	Patients with and ADL score of 7-14.		SSA	20
CLINICALLY COMPLEX – Patients with burns, coma, septicemia, pneumonia, foot wounds, internal bleeding, dehydration, chemotherapy, wounds, kidney failure, urinary tract infections oxygen or transfusions.	Patients have an ADL score of 17-18 with depression		CC2	20
	Patients have an ADL score of 17-18 without depression		CC1	20
	Patients have an ADL score of 12-16 with depression		CB2	20
	Patients have an ADL score of 12-16 without depression		CB1	20
	Patients have an ADL score of 4-11 with depression		CA2	20
	Patients have an ADL score of 4-11 without depression		CA1	20
IMPAIRED COGNITION – Patients with poor cognitive performance (Score on MDS 2.0 cognitive performance scale of >= 3)	ADL score of 6-10 and receiving nursing rehabilitation		IB2	–
	ADL score of 6-10, *not* receiving nursing rehabilitation		IB1	–
	ADL score of 4-5 and receiving nursing rehabilitation		IA2	–

TABLE 2-20--RESOURCE UTILIZATION GROUPS (RUGS) CATEGORIES AND PAYMENT ADD-ONS-continued

Service Category	Clinical condition/ service need	RUG-III Groups	Payment Add-on (in percent)
	ADL score of 4-5 and *not* receiving nursing rehabilitation	IA1	–
BEHAVIOR ONLY – Patients with behavior symptoms such as wandering, hallucinations, or physical or verbal abuse of others (unless other category would place patient in other category).	ADL score of 6-10, and receiving nursing rehabilitation services.	BB2	–
	ADL score of 6-10 and *not* receiving nursing rehabilitation services.	BB1	–
	ADL score of 4-5, and receiving nursing rehabilitation services.	BA2	–
	ADL score of 4-5, and *not* receiving nursing rehabilitation services.	BA1	–
PHYSICAL FUNCTION REDUCED – No special clinical conditions; RUG groups are based solely on the patient's ability to perform activities of daily living.	Patient has an ADL score of 16 - 18 and is receiving nursing rehabilitation.	PE2	–
	Patient has an ADL score of 16 - 18 and is *not* receiving nursing rehabilitation.	PE1	–
	Patient has an ADL score of 11 - 15 and is receiving nursing rehabilitation.	PD2	–
	Patient has an ADL score of 11 - 15 and is *not* receiving nursing rehabilitation.	PD1	–
	Patient has an ADL score of 9-10 and is receiving nursing rehabilitation.	PC2	–
	Patient has an ADL score of 9-10 and is *not* receiving nursing rehabilitation.	PC1	–
	Patient has an ADL score of 6-8 and is receiving nursing rehabilitation.	PB2	–
	Patient has an ADL score of 6-8 and is *not* receiving nursing rehabilitation.	PB1	–
	Patient has an ADL score of 4-5 and is receiving nursing rehabilitation.	PA2	–
	Patient has an ADL score of 4-5 and is *not* receiving nursing rehabilitation.	PA1	–

Source: *Federal Register,* May 12, 1998, vol. 63, no. 91, p. 26262 and *Federal Register*, October 5, 1998, vol. 63, no. 192, pp. 53303-6.

BBRA 99 increased payments for 15 RUGS by 20 percent beginning April 1, 2000 and ending when the Secretary implements refinements to the RUGs. The RUGs that were increased were for rehabilitation services, extensive services, special care services, and clinically complex services. BIPA 2000 modified the add-on to correct for a payment anomaly created by BBRA 99 where several of the mid-intensity rehabilitation RUGs were paid at a higher rate than the high intensity rehabilitation RUGS. These temporary increases result in additional payments to SNFs of approximately $1 billion a year.

Since the inception of SNF PPS, CMS has been conducting research on refinements to the RUGs. In April, 2000 the Secretary proposed refining the RUGs by adding payment categories to better compensate SNFs for providing care to medically complex patients as well as to better account for the "non-therapy

ancillary service" costs (such as prescription drugs and respiratory therapy). However, the proposal was withdrawn when, upon further analysis, CMS determined that the existing RUGs did a better job than the proposed ones in describing differences in patient resource use. Since then, the Secretary has not proposed any refinements. In the SNF PPS proposed rule published May 16, 2003, CMS announced that the RUGs would not be refined for FY 2004, thus keeping in place the temporary add-on payments. A press release on the proposed rule stated, "After careful review of the available data, CMS determined that the research is not sufficiently advanced at the present time to implement the refinements this year." CMS is continuing its research on refinements to the RUGs system. BIPA 2000 requires the Secretary to study different systems for categorizing SNF patients and to report to Congress by January 1, 2005 with the results and any recommendations for changing the SNF PPS statute.

Wage Adjustment--The final adjustment under SNF PPS is to adjust for differences in wages between geographic areas. The labor-related portion of the payment rate is approximately 76 percent. The statute gives the Secretary discretion to use the wage index he finds appropriate. The Secretary uses the most recent hospital wage index to adjust SNF PPS payments. In 2001, the Secretary explored using SNF wages to construct a SNF PPS wage index. The proposal was not adopted for several reasons: reliability of the existing data (there were significant variations in the SNF-specific wage data and a large number of SNFs were unable to provide adequate wage and hourly data); SNF record keeping burden (SNFs would have to keep detailed data, submitting it to fiscal intermediaries annually, and facing audit of those data); and significant resource commitment by CMS (the editing, reviewing, and auditing of the data for approximately 14,000 SNFs would require significant new resources).

Payment Calculation--As discussed above, SNF PPS payments are daily payments. The urban or rural unadjusted Federal per diem rate is broken down into four categories, two of which are adjusted for case mix using the patient's RUG. Each of the RUGs is then broken into a labor-related and non labor-related share and the labor portion is multiplied by the wage index for the area in which the SNF is located. The non-labor portion of the base payment amount is added back in to arrive at the total daily payment. The payment formula is: Daily payment = (Labor-related case-mix adjusted rate x area wage index) + (non-labor-related case-mix adjusted rate). An example of the calculations is shown in Table 2-21. The case-mix adjusted rate = (Nursing component of Federal Rate x Nursing weight for RUG)+(Therapy component of Federal Rate x Therapy weight for RUG)+ (Therapy non-case mix component)+(Non-case mix component).

Outliers--The statute does not permit payments for outliers under SNF PPS. In the other PPSs that have outlier payments, the statute contains explicit authority for the Secretary to make outlier payments.

Updates--The SNF Federal rates are updated annually using the SNF market basket index. The SNF market basket index is a measure of change in the price of goods and services used in providing care for Medicare beneficiaries in a SNF. For FY 2004, SNFs received a full market basket update of 3.0 percent. In addition, for

FY 2004, the Secretary issued a regulation that corrected cumulative forecast error in the market basket since SNF PPS began on July 1, 1998. As a result the FY 2004 rates will be increased by an additional 3.26 percent.

TABLE 2-21--EXAMPLE OF SNF PPS DAILY PAYMENT CALCULATION FOR A SNF LOCATED IN CHICAGO, ILLINOIS FOR SELECTED RUGS

RUG Group	Labor Related	Wage Index	Wage Adjusted Amount	Non-labor related	Adjusted Federal Rate	BBRA/ BIPA Adjustment	Daily Payment
RVC	$268.21	1.0848	$290.95	$82.98	$373.93	6.7 percent	$398.99
RHA	207.28	1.0848	224.86	64.13	288.99	6.7 percent	308.35
SSC	172.65	1.0848	187.29	53.41	240.70	20 percent	288.84
IA2	117.07	1.0848	127.00	36.22	163.22	--	163.22

Source: *Federal Register*, August 4, 2003, vol 68, no. 149, pp 46040 – 46057.

Payments Outside the PPS--BBRA expanded the list of services that are excluded by statute from the SNF PPS: certain chemotherapy items and administration services, certain radioisotope services, certain prosthetic devices, and ambulance services furnished in conjunction with renal dialysis treatments. BBRA required that any increase in total payments that result from these exclusions be budget neutral, that is, that the Federal per-diem amounts be reduced proportionate to the payments.

SNF payments and utilization

For a number of years, SNF care was one of Medicare's fastest growing benefits. Table 2-22 shows that SNF utilization and spending first began to increase substantially in 1988 and 1989. These increases can be traced to changes that occurred in the benefit at that time. First, HCFA issued new coverage guidelines that became effective early in 1988. Prior to this time, studies had pointed to a lack of adequate written guidance on coverage criteria that led to inconsistencies in coverage decisions for a benefit that was intended to be uniform across the country. As a result, many SNFs were reluctant to accept Medicare beneficiaries because of the possibility that a submitted claim would be retroactively denied. The 1988 guidelines clarified coverage criteria by providing numerous examples of covered and noncovered care. Furthermore, the guidelines explained that even when a patient's full or partial recovery is not possible, care could be covered if it were needed to prevent deterioration or to maintain current capabilities. Previously, some care had been denied coverage because patients' health status was not expected to improve.

The second major, though temporary, change in Medicare's SNF benefit came in 1988 with the enactment of the Medicare Catastrophic Coverage Act (MCCA). Effective beginning in 1989, this legislation eliminated the SNF benefit's prior hospitalization requirement; revised the coinsurance requirement to be equal to 20 percent of the national average estimated per-diem cost of SNF services for the first 8 days of care; and authorized coverage of up to 150 days of care per

calendar year (rather than 100 days per spell of illness). These changes were repealed in 1989, and the SNF benefit's structure assumed its prior form. Studies have suggested that the coverage guidelines and MCCA changes together might have caused a long-run shift in the nursing home industry toward Medicare patients that did not end with repeal of MCCA.

Table 2-22 shows that SNF spending in calendar year 1990 stood at $2.3 billion; by 1997 it had increased to $12.9 billion, for an average annual growth rate of 28 percent. With implementation of the PPS payment system in mid-1998, however, the rate of increase dropped precipitously: between 1997 and 1998 payments decreased 0.9 percent, and payments decreased by 18.3 percent in 1999. Between 1992 and 1997 the number of Medicare beneficiaries receiving SNF care doubled from 778,000 to 1.5 million. The number of covered days grew from 27 million to 50 million, or by 85 percent. After the implementation of SNF PPS in July 1998, spending dropped below that of earlier years. Not until 2001 did SNF spending exceed 1998 levels. This drop in spending has been attributed to both increased activities in preventing fraud and abuse and to the implementation of the new PPS. Payment increases contained in BBRA 99 and BIPA 2000 helped account for the increase in payments seen after 1999.

TABLE 2-22--SKILLED NURSING FACILITY PAYMENTS, PEOPLE SERVED, AND DAYS COVERED BY MEDICARE, CALENDAR YEARS 1988-2002

Year	Payments (In millions)	Percent Change	People served (In thousands)	Percent Change	Covered days (In thousands)	Percent Change
1988	$925	--	384	--	10,669	--
1989	3,482	276.4	636	65.4	29,839	179.7
1990	2,329	-33.1	638	4.7	23,781	-20.3
1991	2,737	17.5	671	4.9	22,255	-6.4
1992	3,990	45.8	778	16.3	27,013	21.4
1993	5,368	34.5	903	16.1	31,446	16.4
1994	7,681	43.1	1,063	17.7	37,945	20.7
1995	9,183	19.6	1,233	16.0	43,116	13.6
1996	11,248	22.5	1,373	11.4	47,515	10.2
1997	12,944	15.1	1,503	9.5	49,905	5.0
1998	12,828	-0.9	1,510	0.5	48,535	-2.8
1999	10,486	-18.3	1,447	-4.2	45,290	-6.7
2000	11,263	7.4	1,468	1.5	46,708	3.1
2001	13,849	23.0	NA	NA	50,578	8.3
2002	14,427	4.2	NA	NA	52,725	4.2
Average annual percent change:						
1988-1997 (pre-BBA)						
	--	34.1%	--	16.4%	--	18.7%
1997-2002 (post-BBA)						
	--	2.2%	--	NA	--	1.1%

Note: Payments are incurred Part A expenditures and do not include beneficiary cost sharing.
NA- Not applicable.
Source: CRS analysis of data from CMS Office of the Actuary and Office of Research, Development and Information.

HOME HEALTH SERVICES

Coverage and Benefits

The Medicare home health benefit has specific statutory eligibility criteria: a beneficiary must be confined to his or her home (that is, be "homebound"), be under the care of a physician, and need skilled nursing care on an intermittent basis or other skilled therapy care. A homebound individual is defined as one who cannot leave home without a considerable and taxing effort, or who requires the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving the home is medically contraindicated. Absences from home may occur infrequently for short periods of time for purposes such as to receive medical treatment, attend certain adult day care programs, or attend church. Skilled care includes skilled nursing or therapy (physical, speech/language, occupational) services that are delivered under the care of a physician and in accordance with a plan of care that is periodically reviewed by a physician. Skilled nursing care and home health aide services must be provided on a part-time or intermittent basis, which is defined as "less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as the need for care, less than 8 hours each day or 35 or fewer hours per week)."

For beneficiaries meeting the qualifying criteria, Medicare's home health benefit covers the following services:

1. Part-time or intermittent nursing care provided by or under the supervision of a registered nurse;
2. Physical or occupational therapy or speech-language pathology services;
3. Medical social services;
4. Part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;
5. Medical supplies (excluding drugs and biologicals) and durable medical equipment (DME);
6. Medical services provided by an intern or resident in training under an approved training program with which the agency may be affiliated; and
7. Certain other outpatient services which involve the use of equipment that cannot readily be made available in the beneficiary's home.

Home health care is covered by Medicare as long as the care is medically reasonable and necessary for the treatment of illness or injury. Although the number of home health visits a beneficiary may receive is unlimited, services must be provided pursuant to a plan of care that is prescribed and periodically reviewed by a physician. In general, Medicare's home health benefit is intended to serve beneficiaries needing acute medical care requiring the services of skilled health care personnel. It was never envisioned as providing coverage for the nonmedical supportive care and personal care assistance needed by chronically impaired persons. It is not a long-term care program for the disabled or the frail elderly. Beneficiaries do not have any copayments for home health services.

Home health aide visits include "hands-on personal care to the beneficiary or

services that are needed to maintain the beneficiary's health or to facilitate treatment of the beneficiary's illness or injury." Covered home health aide services include personal care of a patient, simple dressing changes that do not require the skills of a licensed nurse and assistance with medications that ordinarily are self-administered and do not require the skills of a licensed nurse.

Home health services are provided by private or public home health agencies (HHAs) that specialize in provision of such services and that are certified to participate in Medicare by CMS. HHAs may be public or government-sponsored entities, private nonprofit agencies, or proprietary for-profit agencies. Hospitals may own or sponsor an HHA. Home health care givers may be employees of the HHA or may work for an agency under contract. Often, Medicare beneficiaries constitute the great majority of an HHA's caseload, although other users include individuals covered by Medicaid and those with private insurance or who pay out of pocket.

Financing for Home Health Benefits

The financing for the home health care benefit is split between the Hospital Insurance Trust Fund (Part A) and the Supplementary Medical Insurance Trust Fund (Part B). At the inception of the home health benefit, Part A paid for up to 100 home health visits for beneficiaries enrolled in Part A and who had had a 3-day prior hospitalization. Home health care was also covered under Part B, up to 100 visits, for beneficiaries who had no prior hospitalization, or who had exhausted their 100 Part A visits, or who had Part B coverage only. The Omnibus Budget Reconciliation Act of 1980 liberalized the rules governing Medicare's coverage of home health services, including eliminating the requirement for a prior hospitalization and removing the limitation on the number of visits. This had the effect of shifting the financing for home health services almost entirely over to the Part A Trust Fund. The only beneficiaries for whom Part B payments were made were those who had no Part A coverage.

BBA 97 reimposed joint financing of the home health benefit between Parts A and B by gradually transferring those home health services unassociated with a hospital stay from Part A to Part B. Medicare Part A covers the first 100 visits following a 3-day hospital stay or a SNF stay. The transfer was phased in over a 6-year period. Transferring certain certain home health service costs to the Part B Trust fund results in increased outlays and thus increased Part B premium costs to beneficiaries. This increased cost in premiums was phased in over 7 years. Beneficiaries without Part B coverage receive unlimited Part A coverage for home health services.

Payment

Prior to implementation of a congressionally mandated prospective payment system, Medicare paid for home health care on a retrospective cost-based basis. This meant that HHAs were paid for the reasonable costs (as defined by the program) they incurred in providing care to Medicare beneficiaries. These reasonable costs were determined at the end of the HHAs fiscal year, and were

subject to certain limitations. Prior to BBA 97, HHAs had one cost limit: a limit on the costs of providing each visit. This "per-visit cost limit" was applied in the aggregate – that is, the limit was calculated by multiplying the cost limit by all the Medicare visits the agency made in the year -- not to individual visits. The per-visit cost limit gave agencies an incentive to control the costliness of the visits provided. However, agencies could easily circumvent the limit by providing two short visits rather than one long visit. In the period preceding BBA 97, the number of visits provided to Medicare beneficiaries increased dramatically as did Medicare expenditures for home health services (see Table 2-25). In an attempt to control the costs of the care provided to Medicare beneficiaries, Congress, in BBA 97, reduced the per-visit cost limits and imposed an additional cost limit, the aggregate per beneficiary limit, until prospective payment could be implemented. The reduced and new cost limits were called the interim payment system. The aggregate per beneficiary limit was calculated by multiplying the limit by the number of Medicare beneficiaries served by the agency. It was based on the average costs incurred by agencies during agencies' fiscal year ending before October 1, 1994. After BBA 97, HHAs were reimbursed the lesser of: (1) their actual reasonable costs; (2) their reasonable costs subject to the per visit limit; or (3) their reasonable costs subject to the aggregate per beneficiary limit.

Prospective payment system--In BBA 97, Congress required that a prospective payment system (PPS) for home health care be implemented for cost reporting periods beginning on or after October 1, 1999. The effective date of home health PPS was amended to October 1, 2000, for all agencies, because of the inability of CMS to make systems changes for the new payment system while the agency was fixing its computer systems for the year 2000 computer problems.

Home health prospective payment involves grouping patients according to the type and intensity of services they require and setting a payment rate for each payment group. Payment is based on the unit of payment adjusted for the area wages in which a beneficiary resides and is adjusted for the care needs of the beneficiary. Like other PPSs that pay health care providers for care to Medicare beneficiaries on the basis of predetermined, fixed amounts, Medicare payments to HHAs are intended to pay the agency for its Medicare beneficiary costs on average. That is, although the payment is a predetermined rate, an agency's actual costs may be above or below that amount for an individual patient. The incentive agencies have is to manage costs so that, on average, costs do not exceed the PPS average amounts. HHAs that provide the services at lower costs than the Medicare payment are able to keep the difference.

Unit of Payment--Under home health (HH) PPS, an HHA receives a payment for a 60-day episode of care for beneficiaries. The 60-day episode includes skilled nursing, therapy, aide visits, medical supplies, and medical social workers. Physician services, durable medical equipment and osteoporosis drugs are not included in the HH PPS. The 60-day episode base payment, called the "national standardized 60-day episode rate" is based on actual, audited FY 1997 home health costs that have been trended forward for inflation. The base payment amount for FY2003 is $2,159.39 for a 60-day episode of care. There is not a distinction

between urban and rural base payment amounts.

Wage Adjustment--The unit of payment is adjusted to account for differences in the area wages. The statute gives the Secretary discretion to use the wage index he finds appropriate and explicitly authorizes the Secretary to use the hospital wage index for home health PPS. The Secretary uses the previous year's hospital wage index (that does not contain the reclassifications or floors in the hospital wage index used to adjust hospital PPS payments) to adjust for differences in area wages. In FY 2004, the FY 2003 pre-floor and pre-reclassified hospital wage index is used to adjust payments. The wage index for the area in which the beneficiary is actually served is used to adjust the payments. CMS has explored using a wage index specific to HHAs in the past, but has not adopted one because the earlier efforts had data and methodological issues.

Case Mix System--The statute requires the Secretary to develop "...appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services." The case mix system developed adjusts the base payment rate for the treatment and care needs of beneficiaries and is called Home Health Resource Groups (HHRGs). The HHRGs estimate the resource use for specific combinations of clinical, functional and service levels. There are 4 clinical severity levels, 5 functional severity levels, and 4 services utilization levels. The combinations result in 80 HHRGs. Each combination defines one of the 80 groups in the case-mix system. Each patient is assigned to one of the groups as determined following an assessment of the patient's condition and care needs using the Outcome and Assessment Information Set (OASIS). A patient with high clinical severity, moderate functional severity, and low services utilization severity is placed in the same group (C3F2S1) with all other patients whose summed scores place them in the same set of severity levels for the three dimensions. Table 2-23 shows the HHRGs and their relative case mix weights.

Payment Calculation--The standardized 60-day episode rate is adjusted for the area wage index where the beneficiary served resides and for case mix using the applicable HHRG. To calculate payment, the episode rate (in column a of Table 2-24) is multiplied by the labor portion (0.77668) and then by the appropriate area wage index (column c). The result is added to the non-labor portion of the episode rate (column d). That sum (in column e) is multiplied by the appropriate HHRG weight (column g) to arrive at a 60-day episode payment.

TABLE 2-23--HOME HEALTH RESOURCE GROUPS AND RELATIVE CASE-MIX WEIGHTS, FISCAL YEAR 2000

HHRG Group	HHRG Description			Case Mix Weight
	Clinical	Functional	Service	
C0F0S0	Min	Min	Min	0.5265
C0F0S1	Min	Min	Low	0.6074
C0F0S2	Min	Min	Mod	1.4847
C0F0S3	Min	Min	High	1.7364
C0F1S0	Min	Low	Min	0.6213
C0F1S1	Min	Low	Low	0.7022
C0F1S2	Min	Low	Mod	1.5796
C0F1S3	Min	Low	High	1.8313
C0F2S0	Min	Mod	Min	0.7249
C0F2S1	Min	Mod	Low	0.8058
C0F2S2	Min	Mod	Mod	1.6831
C0F2S3	Min	Mod	High	1.9348
C0F3S0	Min	High	Min	0.7629
C0F3S1	Min	High	Low	0.8438
C0F3S2	Min	High	Mod	1.7212
C0F3S3	Min	High	High	1.9728
C0F4S0	Min	Max	Min	0.9305
C0F4S1	Min	Max	Low	1.0114
C0F4S2	Min	Max	Mod	1.8887
C0F4S3	Min	Max	High	2.1404
C1F0S0	Low	Min	Min	0.6221
C1F0S1	Low	Min	Low	0.703
C1F0S2	Low	Min	Mod	1.5803
C1F0S3	Low	Min	High	1.832
C1F1S0	Low	Low	Min	0.7169
C1F1S1	Low	Low	Low	0.7978
C1F1S2	Low	Low	Mod	1.6752
C1F1S3	Low	Low	High	1.9269
C1F2S0	Low	Mod	Min	0.8205
C1F2S1	Low	Mod	Low	0.9014
C1F2S2	Low	Mod	Mod	1.7787
C1F2S3	Low	Mod	High	2.0304
C1F3S0	Low	High	Min	0.8585
C1F3S1	Low	High	Low	0.9394
C1F3S2	Low	High	Mod	1.8168
C1F3S3	Low	High	High	2.0684
C1F4S0	Low	Max	Min	1.0261
C1F4S1	Low	Max	Low	1.107

TABLE 2-23--HOME HEALTH RESOURCE GROUPS AND RELATIVE CASE-MIX WEIGHTS, FISCAL YEAR 2000-continued

HHRG Group	HHRG Description			Case Mix Weight
	Clinical	Functional	Service	
C1F4S2	Low	Max	Mod	1.9843
C1F4S3	Low	Max	High	2.236
C2F0S0	Mod	Min	Min	0.7965
C2F0S1	Mod	Min	Low	0.8774
C2F0S2	Mod	Min	Mod	1.7548
C2F0S3	Mod	Min	High	2.0065
C2F1S0	Mod	Low	Min	0.8914
C2F1S1	Mod	Low	Low	0.9723
C2F1S2	Mod	Low	Mod	1.8496
C2F1S3	Mod	Low	High	2.1013
C2F2S0	Mod	Mod	Min	0.9949
C2F2S1	Mod	Mod	Low	1.0758
C2F2S2	Mod	Mod	Mod	1.9532
C2F2S3	Mod	Mod	High	2.2048
C2F3S0	Mod	High	Min	1.0329
C2F3S1	Mod	High	Low	1.1139
C2F3S2	Mod	High	Mod	1.9912
C2F3S3	Mod	High	High	2.2429
C2F4S0	Mod	Max	Min	1.2005
C2F4S1	Mod	Max	Low	1.2814
C2F4S2	Mod	Max	Mod	2.1588
C2F4S3	Mod	Max	High	2.4105
C3F0S0	High	Min	Min	1.1973
C3F0S1	High	Min	Low	1.2782
C3F0S2	High	Min	Mod	2.1556
C3F0S3	High	Min	High	2.4073
C3F1S0	High	Low	Min	1.2922
C3F1S1	High	Low	Low	1.3731
C3F1S2	High	Low	Mod	2.2504
C3F1S3	High	Low	High	2.5021
C3F2S0	High	Mod	Min	1.3957
C3F2S1	High	Mod	Low	1.4766
C3F2S2	High	Mod	Mod	2.354
C3F2S3	High	Mod	High	2.6056
C3F3S0	High	High	Min	1.4337
C3F3S1	High	High	Low	1.5147
C3F3S2	High	High	Mod	2.392
C3F3S3	High	High	High	2.6437
C3F4S0	High	Max	Min	1.6013
C3F4S1	High	Max	Low	1.6822
C3F4S2	High	Max	Mod	2.5596
C3F4S3	High	Max	High	2.8113

Source: *Federal Register,* July 3, 2000, Vol. 65, No. 128, p. 41202-3.

TABLE 2-24—EXAMPLE OF HOME HEALTH PPS 60-DAY EPISODE PAYMENT CALCULATION FOR AN HHA LOCATED IN CHICAGO, IL FOR SELECTED HHRGS

(a) FY 2004 Episode Rate	(b) Labor Portion [(a)x0.77668]	(c) Chicago Wage Index	(d) Non-Labor Portion	(e) Wage-adjusted rate [[(b)x(c)]+(d)]	(f) HHRG	(g) HHRG Weight	(h) 60-Day Episode Payment[1] [(e)x(g)]
$2,230.65	$1,732.50	1.1044	$498.15	$2411.52	C1F4S3	2.2360	$4,392.16
$2,230.65	$1,732.50	1.1044	$498.15	$2411.52	C0F3S1	0.8438	$2,034.84

[1] Episode payment before additional payment adjustments such as outliers or partial episode payments.
Source: *Federal Register*, July 3, 2000 vol. 65, no. 129, *Federal Register*, July 2, 2003, vol. 68, no. 127.

HHAs are paid 60 percent of the wage- and case mix- adjusted payment after submitting a request for anticipated payment (RAP). The RAP may be 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. Depending upon the circumstances additional adjustments such as an outlier payment or a significant change in condition adjustment may be made to the adjusted episode payment. These additional adjustments are described below.

Updates--The home health 60-day episode rate is updated annually using the home health market basket index. The home health market basket index is a measure of change in the price of goods and services used in providing care for Medicare beneficiaries receiving home care. For FY 2004, agencies received a full market basket update of 3.3 percent.

Outliers--The outlier adjustment provides additional payment to an HHA when the cost of an episode of care is unusually large. Outlier payments are made for episodes whose estimated costs exceed a threshold amount for each HHRG. Five percent of total home health payments are set aside for outlier payments.

Significant Change in a Beneficiary's Condition (SCIC)--An HHA's payments can be modified within a patient's 60-day episode when a significant change in a beneficiary's condition occurs. To obtain this adjustment, an HHA must obtain the necessary change order from the physician; note the required changes in treatment in the beneficiary's plan of care; and complete a new OASIS evaluation, which will produce a new case-mix adjustment factor. Payment will be an amount that is proportional between the HHRG prior to the change and the HHRG after the significant change in condition.

Partial Episode Payment--The partial episode payment adjustment is made if a beneficiary transfers from one HHA to another HHA during a 60-day episode. The first HHA to provide care will have its payment reduced by a portion equal to the amount of time during the 60-day episode in which care was provided. The second HHA will conduct an assessment, and a new, 60-day episode of care will begin.

Low Utilization Payment Adjustment (LUPA)--The PPS payment for an agency is adjusted if a beneficiary's care is delivered in 4 or fewer visits. The payment is a standardized, service-specific per-visit amount multiplied by the number of visits actually provided during the episode.

Background and Trends in Medicare HHA Utilization and Spending

During the first 10 years of the Medicare Program, home health care accounted for less than 2 percent of total Medicare spending. Although home health spending was increasing rapidly (at an average annual rate of about 23 percent between 1970 and 1980), Medicare spending overall was also increasing significantly (the average annual rate of growth was about 17 percent between 1970 and 1980). Between 1980 and about 1990 home health grew to 2 to 3 percent of total program spending reflecting the faster growth in home health spending than Medicare as a whole. This small increase reflected the 1980 liberalizations in the home health benefit as well as the effect the inpatient hospital prospective payment system had on overall Medicare spending. Some analysts had predicted that the inpatient PPS (which began in 1984) would lead to even larger growth in home health care utilization by Medicare beneficiaries than had occurred in the prior decade. However, home health care spending increases that might have occurred as a result of the inpatient PPS were offset by changes in the law and in certain administrative procedures. For instance, the 1984 Deficit Reduction Act required HCFA to reduce the number of "fiscal intermediaries" with which HCFA contracts to process Medicare home health care claims. These entities approve or deny beneficiary eligibility for home health care as well as HHA claims for payment. As HCFA reduced the number of fiscal intermediaries, eligibility and claims decisions became more standardized. HCFA also intensified educational programs for claims processors, required HHAs to submit increased documentation with each claim, and increased the number of claims subjected to in-depth medical reviews. The home health care claims denial rate rose from 3.4 percent in 1985 to 7.9 percent in 1987. These actions served to moderate the rate of growth of the home health benefit.

A significant event in the history of the Medicare home health benefit was settlement of a class action lawsuit filed in 1988 (Duggan v. Bowen) which challenged HCFA's interpretation of the "part-time or intermittent" provision in section 1861(m) of the Social Security Act. As a result of the decision, HCFA revised the agency's policy regarding the interpretation of the statutory language, changing the policy interpretation from part-time *and* intermittent to part-time *or* intermittent. This change allowed the number of visits to be increased because they no longer had to be "intermittent" but could be made on a daily basis.HCFA's revised guidelines also loosened the claims procedures that had been tightened between 1985 and 1987. The revised guidelines may have opened the door to eligibility for persons who have ongoing medical problems that require personal care assistance associated more with long-term care rather than acute care. From 1987 to 1997 the number of beneficiaries receiving home health services more than doubled and the average number of visits per home care patient increased more than threefold, from 23 visits in 1987 to 73 in 1997 (Table 2-25). During this time

period, the number of HHAs participating in Medicare also increased sharply, growing from 5,686 agencies in 1989 to 10,492 in 1997. This dramatic growth in the number of beneficiaries served and the number of visits provided also resulted in similarly dramatic increase in Medicare spending for home health. Home health spending rose from $1.9 billion in 1987 to about $17.5 billion in 1997, an average annual increase of almost 25 percent (Table 2-25). This growth led to changes in payment in the BBA, as well as other provisions that affected HHAs, and also led to scrutiny by the HHS Office of the Inspector General and the General Accounting Office regarding fraudulent practices by some home health agency operators. CMS changed a number of practices regarding home health agencies and initiated a moratorium on allowing new HHAs to enter the Medicare program from September 1997 through January 1998.

After the BBA, Medicare payments to HHAs decreased sharply, falling more than 35 percent in the first full year the aggregate per beneficiary cost limits were in place and an additional 24 percent in the second year. The number of beneficiaries served decreased more than 10 percent a year for the three years after BBA passed. This decrease was due to the stepped up program integrity activities directed at HHAs and to a change in a qualifying service by BBA.[9] The average number of visits per beneficiary served also decreased dramatically, falling almost 30 percent in the first full year after BBA due to the application of the interim payment system.

After implementation of the HH PPS October 1, 2000, payments increased by 8.5 percent in 2001 and by 13 percent in 2002. The number of visits and, to a lesser degree, the number of beneficiaries served, continued to decline after the implementation of PPS. In 2001, the average number of visits per person dropped to 28 and the number of beneficiaries served per thousand dropped to 71.

HOSPICE SERVICES

Coverage and benefits

Medicare covers hospice care for terminally ill beneficiaries, in lieu of most other Medicare services related to the curative treatment of their illness. Beneficiaries who elect hospice may still receive curative treatments for illnesses or injuries unrelated to their terminal illness and they may disenroll from hospice at any time. Congress established the hospice benefit in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) for a period of 3 years. Congress made the benefit permanent in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

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[9] BBA 97 removed venipuncture services from the list of skilled services that was used in determining beneficiary eligibility for the home health benefit. Anecdotally, venipuncture, the drawing of blood, had been seen as a way for some HHAs to deliver frequent aide services to beneficiaries that needed no other skilled care. Furthermore, venipuncture was a covered Part B service and many believed that beneficiaries would continue to receive needed care.

TABLE 2-25 -- MEDICARE HOME HEALTH AGENCY PAYMENTS, PEOPLE SERVED, AND VISITS, CALENDAR YEARS 1987-2002

Year	Payments (in millions)	Percent change	People served			Visits		
			Number	Per 1000 enrolled	Percent change	Number (in thousands)	Per person served	Percent change
1987	$1.9	--	1,564.5	48	--	35,589	23	
1988	2.1	8.5	1,601.7	49	2.1	37,129	23	1.9
1989	2.6	24.3	1,724.9	51	4.1	46,296	27	15.8
1990	3.9	51.7	1,967.1	57	11.8	69,386	35	32.4
1991	5.6	43.5	2,242.9	64	12.3	98,643	44	25
1992	7.9	39.4	2,506.2	70	9.4	132,499	53	20.2
1993	10.3	31.6	2,874.1	79	12.9	167,802	58	10.4
1994	13.8	33.1	3,179.2	93	17.7	218,790	69	17.9
1995	16.3	18.2	3,469.4	102	9.7	264,178	76	10.7
1996	17.7	8.6	3,599.7	107	4.9	281,887	78	2.8
1997	17.5	-1.2	3,557.5	108	0.9	260,162	73	-6.6
1998	11.0	-36.8	3,061.6	95	-12.0	159,247	52	-28.9
1999	8.4	-24.3	2,719.7	85	-10.5	112,866	42	-20.2
2000	8.5	1.4	2,461.2	75	-11.8	94,751	39	-7.3
2001	9.2	8.5	2,402.5	71	-5.3	67,985	28	-26.5
2002	10.4	13.0	NA	NA	NA	72,602	NA	NA
Average annual percent change:								
1987-1997	--	24.7	--	--	8.4	--	--	12.4
1997-2002	--	-9.9	--	--	NA	--	--	NA

Note- Payments are on an incurred basis.

NA- Not available.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary and Office of Information Services.

Hospice care emphasizes palliative medical care, that is, relief from pain, and supportive social and counseling services for terminally ill beneficiaries and their families. Services are provided primarily in the patient's home. Hospice is designed to provide a broad range of services including prescription drugs for pain control and symptom management, skilled nursing care, physician services, home health aide services, homemaker services, patient counseling, and family bereavement counseling.

For a person to be considered terminally ill and eligible for Medicare's hospice benefit, the beneficiary's attending physician and the medical director of the hospice (or physician member of the hospice team) must certify that the individual has a life expectancy of 6 months or less. Beneficiaries electing hospice are covered for two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice team must recertify at the beginning of each period that the beneficiary is terminally ill. Services must be provided under a written plan of care established and periodically reviewed by the individual's attending physician and by the medical director of the hospice.

Covered hospice services include the following: (1) nursing care provided by or under the supervision of a registered nurse; (2) physical or occupational

therapy or speech-language pathology services; (3) medical social services; (4) services of a home health aide who has successfully completed a training program approved by the Secretary of the U.S. Department of Health and Human Services (DHHS); (5) homemaker services; (6) medical supplies (including drugs and biologicals) and the use of medical appliances; (7) physician services; (8) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management); (9) counseling, including dietary counseling, for care of the terminally ill beneficiary and for family adjustment to the patient's death (bereavement counseling is not a reimbursable service); and (10) any other item or service which is specified in a patient's plan of care and which Medicare can pay for.

Medicare's hospice benefit is intended to be principally an in-home benefit. For this reason, Medicare law prescribes that respite care, or relief for the primary care giver of the terminally ill patient, may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than 5 days. In addition, the aggregate number of inpatient care days provided in any 12-month period to Medicare beneficiaries electing hospice care can not exceed 20 percent of the total number of days of hospice coverage provided to these persons.

Only two covered hospice services–outpatient drugs or biologicals and respite care–are subject to coinsurance. Outpatient drugs and biologicals are subject to a coinsurance amount that approximates 5 percent of the cost of the drug to the hospice program, except that the amount may not exceed $5 per prescription. For respite care, coinsurance equals 5 percent of program payments for respite, but may not exceed Medicare's inpatient hospital deductible during a hospice coinsurance period (defined as the period when hospice election is not broken by more than 14 days).

Covered services must be provided by a Medicare-certified hospice. Certified hospices must be either public agencies or private organizations primarily engaged in providing covered hospice services and must make services available on a 24-hour basis, in individuals' homes, on an outpatient basis, and on a short-term inpatient basis. Hospices must routinely and directly provide substantially all of the following "core" services: nursing care, medical social services, and counseling services. The remaining hospice services may be provided either directly by the hospice or under arrangements with others. If services are provided through arrangements with other providers, the hospice must maintain professional management responsibility for all such services, regardless of the facility in which the services are furnished.

The hospice program must also have an interdisciplinary group of personnel which includes at least one registered professional nurse and one social worker employed by the hospice; one physician employed by or under contract with the hospice; plus at least one pastoral or other counselor.

Prospective Payment System

In implementing Medicare's hospice benefit, HCFA established a prospective payment methodology in 1983. This early prospective payment system pays hospices according to the general type of care provided to a beneficiary on a daily basis. Unlike other PPSs there is no additional adjustment for case mix. Like other PPSs that pay health care providers for care to Medicare beneficiaries on the basis of predetermined, fixed amounts, Medicare payments to hospices are intended to pay for the costs of care for a hospice beneficiary, on average. That is, although the payment is a predetermined daily rate, a hospice's actual costs may be above or below that amount for an individual patient. The incentive facilities have is to manage costs so that, on average, costs do not exceed the PPS average amounts. Hospices that provide the services at lower costs than the Medicare payment are able to keep the difference.

Unit of Payment-- Under the hospice prospective payment, hospices are paid one of four prospectively determined rates, which correspond to four different levels of care, for each day a Medicare beneficiary is under the care of the hospice. Payment will thus vary by the length of the patient's period in the hospice program as well as by the characteristics of the services (intensity and site) furnished to the beneficiary. Each rate is adjusted for the geographic location in which the service is delivered to account for variations in area wages as described below.

The four rate categories are:

1. *Routine home care*–Routine home care payment is made for a day on which an individual is at home and is not receiving continuous home care. The routine home care rate is paid for every day a patient is at home and under the care of the hospice regardless of whether the hospice actually visits the home and regardless of the volume or intensity of the services provided on any given day as long as fewer than 8 hours of care is provided. The FY 2004 base routine home care rate is $118.08 per day.
2. *Continuous home care*–Continuous home care payment is made for a day on which an individual receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is furnished only during brief periods of crisis and only as necessary to maintain the terminally ill patient at home. Home care must be provided for a period of at least 8 hours before it would be considered to fall within the category of continuous home care. Payment for continuous home care will vary depending on the number of hours of continuous services provided. For FY 2004, the base continuous home care rate is $689.18 for 24 hours or $28.72 per hour.
3. *Inpatient respite care*– Inpatient respite care payment is made for a day on which the individual who has elected hospice care receives care in an approved facility on a short- term (not more than 5 days at a time) basis for the respite of his or her caretakers. For FY 2004, the base inpatient respite care rate is $122.15 per day.
4. *General inpatient care*– General inpatient care payment is made for a day

on which an individual receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. Care may be provided in a hospital, skilled nursing facility (SNF), or inpatient unit of a freestanding hospice. For FY 2004, the base general inpatient care rate is $525.28 per day.

Wage Adjustment--Each of the four payment rates is adjusted for differences in wages between geographic areas. The labor-related portion of the payment rate is approximately 69 percent. The hospital wage index is used to adjust the labor-related portion of the hospice payment rates. The use of the hospital wage index to adjust hospice payments was determined using negotiated rulemaking. As a result, CMS uses the most recent hospital wage index available at the time the Federal Register notice announcing the wage index is published. In addition, also as a product of the negotiated rulemaking, wage index values greater than 0.8 are multiplied by a budget neutrality adjustment. Wage index values below 0.8 are adjusted to be the greater of: (1) a 15 percent increase, subject to a maximum wage index value of 0.8, or (2) the product of multiplying the hospital wage index value for a given area by the budget neutrality adjustment. The budget neutrality adjustment for FY 2004 is 1.061238. For FY 2004, the FY 2003 hospital wage index, adjusted as described above, will be used.

Payment Calculation--The applicable hospice rate category is adjusted for the area wage index where the beneficiary served resides. To calculate payment, the applicable rate category labor portion (in column b of Table 2-26) is multiplied by the appropriate area wage index (column c). The result is added to the non-labor portion of the episode rate (column d). That sum (in column e) is the daily hospice payment amount.

TABLE 2-26—EXAMPLE OF DAILY HOSPICE PAYMENT CALCULATION FOR A HOSPICE LOCATED IN CHICAGO, IL FOR THE FOUR RATE CATEGORIES

(a) Rate Category	(b) Labor Portion	(c) Chicago Wage index	(d) Non-Labor Portion	(e) Wage-adjusted payment [[(b)x(c)]+(d)]
Routine Home Care	$81.13	1.1720	$36.95	$132.03
Continuous Home Care	$473.54	1.1720	$215.64	$800.63
Inpatient Respite Care	$66.12	1.1720	$56.03	$133.52
General Inpatient Care	$336.23	1.1720	$189.05	$583.11

Source: Federal Register, September 30, 2003, vol. 68, no. 189; Program Memorandum A-03-057, July 3, 2003.

Cap Amount-- Medicare law requires that payments to a hospice for care furnished over the period of a year be limited to a “cap amount.” The cap amount is a per beneficiary amount applied on an aggregate rather than a case-by-case basis. Therefore, each individual hospice's cap amount is calculated by multiplying the yearly per beneficiary cap amount by the number of Medicare beneficiaries who received hospice care from the hospice during the cap period. Medicare defines a cap year as the period from November 1 through October 31 of the following year.

The hospice cap for the period November 1, 2002, through October 31, 2003, is $18,661.29 per beneficiary per year, and is not adjusted for variations in area wages.

Updates--Hospice daily payment rates for routine home care, continuous home care, inpatient respite care, and general inpatient care are updated annually by the increase in the hospital market basket. For FY 2004 the update is the full hospital market basket increase of 3.4 percent.

The hospice cap amount is adjusted annually by the percentage change in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U).

Hospice program data

Table 2-27 shows that the number of hospices participating in Medicare grew from 553 in July, 1988 to 2,325 in December, 2002. Freestanding hospices grew at the fastest average annual rate (13 percent) followed by hospital-based hospices (10 percent) and home health agency-based hospices (9 percent). Medicare payments for hospice care in FY 1991 were $446 million and grew to $3.6 billion in FY 2001, an average annual increase of 23 percent (Table 2-28). This growth in spending was fueled by the increased number of beneficiaries using the hospice benefit rather than an increase in the intensity of services provided to beneficiaries. From FY 1991 through FY 2001, the number of beneficiaries using Medicare's hospice benefit increased at an average annual rate of 18 percent. However the average dollar amount spent per beneficiary grew at a more modest 4 percent average annual rate between FY 1991 and FY 2001. The number of days that a beneficiary elects hospice care increased steadily from FY 1991 through 1995, then decreased between 1996 and 1999, before increasing in FY 2000 and FY 2001. The large declines in the number of days in the FY 1996 through FY 1999 period has been attributed to increased enforcement of the "life expectancy" requirement. The increase in days in FY 2000 and 2001 is attributable to educational efforts by CMS regarding the life expectancy requirement – that is, CMS wrote to hospices that hospices will not be penalized if a beneficiary lives longer than 6 months and that the hospice benefit is not limited to 6 months. Of the types of care provided by hospices, continuous home care grew at the fastest rate over the FY 1991 through FY 2001 time period, increasing at an average annual rate of 31 percent. Routine home care had the next highest growth rate, an average annual rate of 24 percent, followed by physician services (21 percent) and general inpatient care (19 percent).

TABLE 2-27--NUMBER OF HOSPICES PARTICIPATING IN MEDICARE BY TYPE OF HOSPICE, 1988-2002

Date	Number of Hospices				
	Freestanding	Hospital-Based	SNF	HHA	Total
7/88	191	138	11	213	553
7/89	220	182	13	286	701
5/90	260	221	12	313	806
9/91	394	282	10	325	1,011
1/92	404	291	10	334	1,039
5/93	499	341	10	438	1,288
8/94	608	401	12	583	1,604
6/95	656	447	18	674	1,795
10/96	762	507	21	800	2,090
12/97	875	559	23	829	2,286
12/98	895	567	22	809	2,293
12/99	934	564	22	774	2,294
12/00	970	557	20	734	2,281
12/01	1,004	554	20	704	2,282
12/02	1,074	558	17	676	2,325
Average Annual Percent Change					
	13.1	10.5	3.2	8.6	10.8

Source: Centers for Medicare & Medicaid Services.

PART B SERVICES - COVERAGE AND PAYMENTS

PHYSICIANS' SERVICES

Coverage

Medicare provides coverage for physicians' services. This category includes surgery, consultation, and home, office and institutional visits. Certain limitations apply for services rendered by dentists, podiatrists, and chiropractors and for the treatment of mental illness. These are referred to as limited licensed practitioners.

Reimbursement - In General

Medicare pays for physicians' services on the basis of a fee schedule which went into effect in 1992. The fee schedule assigns relative values to services. Each of the approximately 7,500 physician service codes is assigned its own relative value. Relative values reflect three factors: physician work, practice expenses, and malpractice costs. These relative values are adjusted for geographic variations in the costs of practicing medicine. Geographically-adjusted relative values are then converted into a dollar payment amount by multiplying by a dollar figure known as the conversion factor. The annual percentage update to the conversion factor equals the Medicare economic index (which measures inflation) subject to an adjustment to match spending for physicians' services under the sustainable growth rate system.

TABLE 2-28 -- MEASURES OF MEDICARE HOSPICE CARE, SELECTED FISCAL YEARS 1991-2001

Category	1991	1993	1995	1996	1997	1998	1999[1]	2000[1]	2001
Cash outlays by provider type (in millions):									
Freestanding	$219	$620	$997	$1,042	$1,123	$1,206	$1,445	$1,740	$2,229
Hospital Based	$92	$205	$319	$331	$345	$373	$400	$465	$539
SNF Based	$9	$23	$26	$25	$13	$17	$17	$19	$22
HHA Based	$126	$304	$508	$546	$543	$575	$573	$672	$821
Total	$446	$1,152	$1,831	$1,944	$2,024	$2,171	$2,435	$2,896	$3,611
Cash outlays by care type (in millions):									
Routine Home Care	$377	$1,005	$1,612	$1,702	$1,770	$1,889	$2,111	$2,508	$3,138
Continuous Home Care	$4	$12	$26	$29	$29	$32	$35	$46	$59
Inpatient Respite Care	$1	$3	$4	$5	$5	$5	$6	$6	$8
General Inpatient Care	$60	$126	$179	$198	$210	$232	$267	$314	$380
Physician Services	$4	$7	$10	$11	$12	$13	$16	$21	$26
Total	$445	$1,152	$1,831	$1,944	$22,024	$2,171	$2,435	$2,896	$3,611
Average dollar amount per beneficiary:									
Freestanding	$4,121	$6,065	$6,451	$6,157	$5,796	$5,689	$5,690	$5,889	$6,583
Hospital Based	$4,234	$5,361	$5,740	$5,333	$5,028	$5,129	$5,214	$5,336	$5,708
SNF Based	$4,198	$5,344	$6,079	$5,953	$5,079	$5,122	$5,537	$5,474	$6,026
HHA Based	$3,993	$5,239	$5,569	$5,313	$4,949	$5,084	$5,145	$5,256	$5,735
Total	$4,108	$5,681	$6,049	$5,747	$5,402	$5,412	$5,471	$5,635	$6,228
Number of beneficiaries by provider type:									
Freestanding	53,184	102,283	151,466	169,285	193,765	211,952	253,981	295,429	338,639
Hospital Based	21,717	38,295	55,631	62,081	68,688	72,804	76,705	87,163	94,348
SNF Based	2,040	4,221	4,272	4,124	2,547	3,288	3,097	3,388	3,619
HHA Based	31,472	57,969	91,239	102,783	109,723	113,096	111,363	127,860	143,195
Total	108,413	202,768	302,608	338,273	374,723	401,140	445,146	513,840	579,801
Average number of days a beneficiary elects hospice care:									
Freestanding	46.2	62.0	62.9	58.5	53.4	50.8	47.1	50.4	53.8
Hospital Based	44.2	53.8	56.7	51.6	47.9	44.1	41.4	44.2	45.2

SNF Based	37.6	42.7	49.3	47.7	19.9	41.0	38.0	41.5	43.7
HHA Based	42.5	52.2	53.8	50.0	45.9	44.0	40.7	42.6	43.9
Total[2]	44.5	57.2	58.8	54.5	50.1	48.6	44.5	47.3	49.9
Number of units by care type:									
Routine Home Care-days	4,667,703	11,324,524	17,257,734	17,862,843	18,189,764	18,454,749	20,236,689	23,498,838	27,965,245
Continuous Home Care-hours	199,309	565,903	1,129,697	1,193,623	1,190,982	1,303,204	1,398,793	1,826,803	2,228,472
Inpatient Respite Care-days	14,867	27,887	45,932	47,218	47,790	47,905	49,530	54,332	62,810
General Inpatient Care-days	161,211	303,245	418,093	451,396	470,593	502,199	565,875	655,753	756,583
Physician Services-procedures	53,491	115,560	165,066	185,970	200,376	204,624	243,270	291,648	365,202

[1]FY 1999 and FY 2000 figures were calculated based on claims from hospices open during FY 2002.

[2]Weighted by the number of beneficiaries in each hospice type.

Note- Totals may not add due to rounding.

Source: Centers for Medicare & Medicaid Services. Standard Analytical Files, 100 percent Final Action Claims.

Calculation of Fee Schedule

The fee schedule has three components: the relative value for the service; a geographic adjustment, and a national dollar conversion factor.

Relative Value--The relative value for a service compares the relative physician work involved in performing one service with the work involved in providing other physicians' services. It also reflects average practice expenses and malpractice expenses associated with the particular service. The relative value for each service is the sum of three components:

– Physician work component, which measures physician time, skill, and intensity in providing a service;
– Practice expense component, which measures average practice expenses such as office rents and employee wages (which, for certain services can vary depending on whether the service is performed in a facility, such as an ambulatory surgical facility, or in a non-facility setting); and
– Malpractice expense component, which reflects average professional liability insurance costs.

Geographic Adjustment--The geographic adjustment is designed to account for variations in the costs of practicing medicine. A separate geographic adjustment is made for each of the three components of the relative value unit, namely a work adjustment, a practice expense adjustment, and a malpractice adjustment. These are added together to produce an indexed relative value unit for the service for the locality. There are 92 service localities nationwide. (Table 2-29 shows the geographic indices used for the 2002-2003 period.)

The geographic adjustments are indexes that reflect cost differences among areas compared to the national average in a "market basket" of goods. The work adjustment is based on a sample of median hourly earnings of workers in six professional specialty occupation categories. The practice expense adjustment is based on employee wages, office rents, medical equipment and supplies, and other miscellaneous expenses. The malpractice adjustment reflects malpractice insurance costs. The law specifies that the practice expense and malpractice indices reflect the full relative differences. However, the work index must reflect only one-quarter of the difference. Using only one-quarter of the difference generally means that rural and small urban areas would receive higher payments and large urban areas lower payments than if the full difference were used.

Conversion Factor--The conversion factor is a dollar figure. The payment for a service equals the geographically adjusted relative value for the service multiplied by the conversion factor. The conversion factor is the same for all services. The conversion factor is updated each year. (See below.) The 2003 conversion factor, which became effective March 1, 2003, is $36.7856. Anesthesiologists are paid under a separate fee schedule which uses base and time units; a separate conversion factor ($17.05 in 2003) applies.

Table 2-30 shows the conversion factors that have applied since implementation of the fee schedule in 1992. For several years during this period, more than one conversion factor applied. However, beginning in 1998, one conversion factor applied for all services.

Annual Update to the Conversion Factor

The conversion factor is updated each year according to a formula specified in law. The intent of the formula is to place a restraint on overall spending for physicians' services. Several factors enter into the calculation of the formula. These include: 1) the Medicare economic index (MEI) which measures inflation in the inputs needed to produce physicians services; 2) the sustainable growth rate (SGR) which is essentially a target for Medicare spending growth; and 3) the update adjustment factor which modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target.

The SGR system was established because of the concern that the fee schedule itself would not adequately constrain increases in spending for physicians' services. While the fee schedule specifies a limit on payments per service, it does not place a limit on the volume or mix of services. The use of SGR targets is intended to serve as a restraint on aggregate spending. The SGR targets are not limits on expenditures. Rather the fee schedule update reflects the success or failure in meeting the target. If total physician expenditures exceed the target, the update for a future year is reduced. If expenditures are less than the target, the update is increased.

TABLE 2-29--GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY, 2002-2003

Locality Name	Work	Practice Expense	Malpractice
Alabama	0.978	0.870	0.807
Alaska	1.064	1.172	1.223
Arizona	0.994	0.978	1.111
Arkansas	0.953	0.847	0.340
Anaheim/Santa Ana, CA	1.037	1.184	0.955
Los Angeles, CA	1.056	1.139	0.955
Marin/Napa/Solano, CA	1.015	1.248	0.687
Oakland/Berkeley, CA	1.041	1.235	0.687
San Francisco, CA	1.068	1.458	0.687
San Mateo, CA	1.048	1.432	0.687
Santa Clara, CA	1.063	1.380	0.639
Ventura, CA	1.028	1.125	0.783
Rest of CA[1]	1.007	1.034	0.748
Rest of CA[1]	1.007	1.034	0.748
Colorado	0.985	0.992	0.840
Connecticut	1.050	1.156	0.966
Delaware	1.019	1.035	0.712
DC+MD/VA Suburbs	1.050	1.166	0.909
Fort Lauderdale, FL	0.996	1.018	1.877
Miami, FL	1.015	1.052	2.528
Rest of FL	0.975	0.946	1.265
Atlanta, GA	1.006	1.059	0.935
Rest of GA	0.970	0.892	0.935
Hawaii/Guam	0.997	1.124	0.834
Idaho	0.960	0.881	0.497
Chicago, IL	1.028	1.092	1.797
East St. Louis, IL	0.988	0.924	1.691

TABLE 2-29--GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY, 2002-2003-continued

Locality Name	Work	Practice Expense	Malpractice
Suburban Chicago, IL	1.006	1.071	1.645
Rest of IL	0.964	0.889	1.157
Indiana	0.981	0.922	0.481
Iowa	0.959	0.876	0.596
Kansas[1]	0.963	0.895	0.756
Kansas[1]	0.963	0.895	0.756
Kentucky	0.970	0.866	0.877
New Orleans, LA	0.998	0.945	1.283
Rest of Louisiana	0.968	0.870	1.073
Southern Maine	0.979	0.999	0.666
Rest of Maine	0.961	0.910	0.666
Baltimore/Surr. Cntys, MD	1.021	1.038	0.916
Rest of Maryland	0.984	0.972	0.774
Metropolitan Boston	1.041	1.239	0.784
Rest of Massachusetts	1.010	1.129	0.784
Detroit, MI	1.043	1.038	2.738
Rest of Michigan	0.997	0.938	1.571
Minnesota	0.990	0.974	0.452
Mississippi	0.957	0.837	0.779
Metropolitan Kansas City, MO	0.988	0.967	0.846
Metropolitan St. Louis, MO	0.994	0.938	0.846
Rest of Missouri[1]	0.946	0.825	0.793
Rest of Missouri[1]	0.946	0.825	0.793
Montana	0.950	0.876	0.727
Nebraska	0.948	0.877	0.430
Nevada	1.005	1.039	1.209
New Hampshire	0.986	1.030	0.825
Northern NJ	1.058	1.193	0.860
Rest of New Jersey	1.029	1.110	0.860
New Mexico	0.973	0.900	0.902
Manhattan, NY	1.094	1.351	1.668
NYC Suburbs/Long I., NY	1.068	1.251	1.952
Poughkpsie/N NYC suburbs, NY	1.011	1.075	1.275
Queens, NY	1.058	1.228	1.871
Rest of New York	0.998	0.944	0.764
North Carolina	0.970	0.931	0.595
North Dakota	0.950	0.880	0.657
Ohio	0.988	0.944	0.957
Oklahoma	0.968	0.876	0.444
Portland, OR	0.996	1.049	0.436
Rest of Oregon	0.961	0.933	0.436
Metropolitan Philadelphia, PA	1.023	1.092	1.413
Rest of Pennsylvania	0.989	0.929	0.774
Puerto Rico	0.881	0.712	0.275
Rhode Island	1.017	1.065	0.883
South Carolina	0.974	0.904	0.279
South Dakota	0.935	0.878	0.406
Tennessee	0.975	0.900	0.592

TABLE 2-29--GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY, 2002-2003-continued

Locality Name	Work	Practice Expense	Malpractice
Austin, TX	0.986	0.996	0.859
Beaumont, TX	0.992	0.890	1.338
Brazoria, TX	0.992	0.978	1.338
Dallas, TX	1.010	1.065	0.931
Fort Worth, TX	0.987	0.981	0.931
Galveston, TX	0.988	0.969	1.338
Houston, TX	1.020	1.007	1.336
Rest of Texas	0.966	0.880	0.956
Utah	0.976	0.941	0.644
Vermont	1.020	0.986	0.539
Virgin Islands	0.965	1.023	1.002
Virginia	0.984	0.938	0.500
Seattle (King County), WA	1.005	1.100	0.788
Rest of Washington	0.981	0.972	0.788
West Virginia	0.963	0.850	1.378
Wisconsin	0.981	0.929	0.939
Wyoming	0.967	0.895	1.005

[1]Payment locality is serviced by two carriers.

Note-Work GCPI is the 1/4 work GPCI required by Section 1848 (1)(A)(iii) of the Social Security Act. GPCIs rescaled by the following factors for budget neutrality: Work=0.99699; Practice Expense=0.99235; Malpractice Expense=1.00215.

Source: DHHS, CMS, Medicare Program, Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2003, Federal Register, December 31, 2003, v67, no251, p.80170.

TABLE 2-30--CONVERSION FACTORS: CALENDAR YEARS 1992-20003

Calendar Year	Services	Conversion Factor
1992	All Services	$31.00
1993	Surgical	31.96
	Nonsurgical	31.25
1994	Surgical	35.16
	Primary Care	33.72
	Other nonsurgical	32.90
1995	Surgical	39.45
	Primary Care	36.38
	Other nonsurgical	34.62
1996	Surgical	40.80
	Primary Care	35.42
	Other nonsurgical	34.63
1997	Surgical	40.96
	Primary Care	35.77
	Other nonsurgical	33.85
1998	All Services	36.69
1999	All Services	34.73
2000	All Services	36.61
2001	All Services	38.26
2002	All Services	36.20
2003	All Services	36.79

Source: CMS, Medicare Program; Physician Fee Schedule Update for Calendar year 2003. Final Rule Federal Register, vol 68. No.40, February 28, 2003.

General Requirements--The annual percentage update to the conversion factor, equals the MEI, subject to an adjustment (known as the update adjustment factor) to match target spending for physicians' services under the SGR system. The conversion factor is further adjusted to meet certain budget neutrality requirements.

Update Adjustment Factor--The update adjustment sets the conversion factor at a level so that projected spending for the year will meet allowed spending by the end of the year. Allowed spending for the year is calculated using the SGR. However, in no case can the update adjustment factor be less than minus 7 percent or more than plus 3 percent.

Beginning in 2001, the update adjustment factor is the sum of: 1) the *prior year adjustment component,* and 2) the *cumulative adjustment component*. The prior year adjustment component is determined by: 1) computing the difference between allowed expenditures for physicians' services for the prior year and the amount of actual expenditures for that year; 2) dividing this amount by the actual expenditures for that year; and 3) multiplying that amount by 0.75. The cumulative adjustment component is determined by: 1) computing the difference between allowed expenditures for physicians' services from April 1, 1996 through the end of the prior year and the amount of actual expenditures during such period; 2) dividing that difference by actual expenditures for the prior year as increased by the SGR for the year for which the update adjustment factor is to be determined; and 3) multiplying that amount by 0.33. Use of both the prior year adjustment component and the cumulative adjustment component allows any deviation between cumulative actual expenditures and cumulative allowed expenditures to be corrected over several years rather than a single year.

Sustainable Growth Rate--The law specifies a formula for calculating the SGR. It is based on changes in four factors: 1) estimated changes in fees; 2) estimated change in the average number of Part B enrollees (excluding Medicare+Choice beneficiaries); 3) estimated projected growth in real gross domestic product (GDP) growth per capita; and 4) estimated change in expenditures due to changes in law or regulations.

By November 1 of each year, (using the best data available as of September 1), CMS is required to publish in the *Federal Register*, the SGRs for three time periods. These periods are the upcoming year, the current year, and the preceding year. Thus the SGR is estimated and revised twice, based on later data.

By November 1, 2002, CMS was to publish an estimate of the SGR for CY2003, a revision of the CY2002 SGR estimated in 2001 and a revision of the CY2001 SGR first estimated 2 years earlier and revised 1 year earlier. Publication of these amounts was first delayed until December 31, 2002. These amounts were subsequently revised as a result of the enactment of the Consolidated Appropriations Resolution, 2003 (CAR) (P.L.108-7) which allowed CMS to go back and use actual data to determine the SGRs for FY 1998 and FY1999 for the purposes of determining future fee schedule updates. Two factors in the SGR calculation accounted for the major differences between estimated and actual data. These were fee-for-service enrollment in Medicare (because fewer people than

expected enrolled in managed care) and changes in the real per capita growth in the GDP. Changing the FY 1998 and FY 1999 numbers to reflect actual data had the effect of increasing the SGR used for the calculation of the 2003 update.

Calculation of the Conversion Factor for 2002 and 2003

As noted above, the annual update to the conversion factor reflects the MEI plus an adjustment to reflect the success or failure in meeting the SGR target. In 2002, the update derived from these calculations resulted in an update of: -4.8 percent. In addition, certain required budget neutrality adjustments were made through adjustments to the conversion factor. The final update to the conversion factor was: -5.4 percent. Thus, the conversion factor for 2002 ($36.1992) was 5.4 percent less than the conversion factor for 2001 ($38.2581). Despite the negative update in 2002, CBO estimates that payments under the physician fee schedule increased from $40.4 billion in 2001 to $44.2 billion in 2002. This is largely attributable to the increase in the volume of services provided to beneficiaries.

As noted, the law requires the fee schedule for the following year to be issued by November 1. However, due to technical complications, publication of the 2003 fee schedule was first delayed until December 31, 2002. It would have provided for an additional 4.4 percent cut. It was revised on February 28, 2003 in response to the enactment of the Consolidated Appropriations Resolution, 2003 (CAR) (P.L.108-7). As a result of the CAR provision, the update for 2003 is 1.6 percent. As a result of the delays, the 2003 fee schedule became effective March 1, 2003.

Table 2-31 shows how the 2003 conversion factor was calculated. The MEI for 2003 is 3.0 percent. The update adjustment factor (after applying the formula described above) is 0.989. An additional statutory reduction (-0.2 percent) applies in 2003. An additional budget neutrality adjustment (-0.4) is made to account for the increase in work relative values for anesthesia services resulting from the 5-year review. This results in a 2003 conversion factor of $36.7856.

TABLE 2-31--CALCULATION OF THE 2003 CONVERSION FACTOR

2002 Conversion Factor	$36.1992
Multiply by *Update* (product of: MEI plus 1 (1.030), update adjustment factor (0.989), and additional statutory reduction (.998, i.e., a 0.2 percent reduction))	x 1.0166
Multiply by budget neutrality adjustment (- 0.4 percent) to account for increase in anesthesia work relative values	x 0.9996
2003 Conversion Factor	$36.7856

Source: Congressional Research Service.

Bonus Payments

The law specifies that physicians who provide covered services in any rural or urban health professional shortage area (HPSA) are entitled to an incentive payment. This is a 10 percent bonus over the amount which would otherwise be paid under the fee schedule. The bonus is only paid if the services are actually provided in the HPSA, as designated under the Public Health Service Act.

Limits on Beneficiary Liability

In General--Medicare payments are made for physicians' services after the annual deductible requirement of $100 has been satisfied. Payment is set at 80 percent of the fee schedule with beneficiaries responsible for the remaining 20 percent, which is referred to as coinsurance. Medicare payment is made either on an “assigned” or “unassigned” basis. By accepting assignment, physicians agree to take the Medicare fee schedule amount as payment in full. Thus, if assignment is accepted, beneficiaries are not liable for any additional out-of-pocket payments. In contrast, if assignment is not accepted, beneficiaries may be liable for charges in excess of the Medicare approved charge, subject to limits. This process is known as balance billing.

When a physician agrees to accept assignment on all Medicare claims in a given year, the physician is referred to as a participating physician. Physicians who do not agree to accept assignment on all Medicare claims in a given year are referred to as nonparticipating physicians. It should be noted that the term “nonparticipating physician” does not mean that the physician doesn’t deal with Medicare. Nonparticipating physicians still treat Medicare patients and receive Medicare payments for providing covered services.. There are a number of incentives for physicians to become participating physicians, the chief of which is that the fee schedule payment amount for nonparticipating physicians is only 95 percent of the recognized amount paid to participating physicians. Additional incentives include more rapid claims payment and widespread distribution of participating physician directories. Nonparticipating physicians may not charge more than 115 percent of Medicare's allowed amount for any service. Medicare's allowed amount for nonparticipating physicians is set at 95 percent of that for participating physicians. Thus, nonparticipating physicians are only able to bill 9.25 percent (115 percent times 95 percent) over the approved amount for participating physicians.

Mental Health Services Payment Limitation--Certain mental health services are subject to a payment limitation under which 50 percent cost-sharing, rather than 20 percent cost-sharing applies. Services subject to the higher cost-sharing are services provided in connection with the treatment of mental, psychoneurotic, and personality disorders of a patient who is not an inpatient of a hospital. The term “mental, psychoneurotic, and personality disorders” is defined as the specific psychiatric conditions described in the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders. The payment limitation applies only to treatment services. It does not apply to diagnostic services. Testing services performed to evaluate a patient's progress during treatment are considered part of treatment and are subject to the higher cost-sharing. The limitation does not apply to partial hospitalization services that are not directly provided by a physician.

Assignment and Participation Data

The total number of assigned claims as a percentage of total claims received

by Medicare carriers is known as the assignment rate. Table 2-32 shows the assignment rate for services provided by physicians, limited licensed practitioners (podiatrists, chiropractors, and optometrists) and non-physician practitioners (such as nurse practitioners and clinical social workers). The assignment rate declined until the mid-1970s when the rate leveled off at about 50 percent. Since 1985, the rate has increased significantly, rising to 98.3 percent of claims and 99.3 percent of covered charges in 2002. Table 2-33 shows the state-by-state assignment rates for services provided by physicians and limited licensed practitioners. Virtually all of these claims (when measured as a percentage of covered charges) are paid on assignment. In 2002, the lowest such rate was in South Dakota and Idaho (94.9 percent) while the highest rate (100 percent) was in Massachusetts.

Physician participation rates have risen significantly since the inception of the participation program in 1984. For the calendar year 2002 participation period, the physician participation rate (including limited licensed practitioners) had risen to 89.7 percent, accounting for 96.7 percent of covered charges (Table 2-34). Specialists in cardiovascular disease had the highest assignment rates. Table 2-35 shows the participation rates by specialty. Table 2-36 shows the percentage of participating physicians and limited licensed practitioners as a percentage of total physicians and limited licensed practitioners for each State.

TABLE 2-32--NET ASSIGNMENT RATES, IN PERCENT, SELECTED FISCAL YEARS 1969-2002

Fiscal Year	Claims	Covered Charges
1969	61.0	NA
1970	61.2	NA
1975	51.9	47.7
1980	51.4	51.3
1985	67.7	67.4
1990	80.9	84.8
1991	82.5	87.6
1992	85.5	90.8
1993	89.2	94.0
1994	92.1	96.0
1995	94.2	97.1
1996	95.6	97.9
1997	96.5	98.3
1998	97.2	98.6
1999	97.5	98.8
2000	97.8	99.0
2001	98.1	99.1
2002	98.3	99.3

[1] Both measures of assignment exclude claims from hospital-based physicians and group-practice prepayment plans that are considered assigned by definition.

NA-Not available.

Source: Centers for Medicare & Medicaid Services.

TABLE 2-33--PHYSICIAN ASSIGNMENT RATES AS PERCENT OF COVERED CHARGES BY STATE, SELECTED YEARS 1985-2002

[In Percent]

Census division/State	1985	1990	1995	2000	2001	2002
National	65.5	83.0	96.8	99.1	99.2	99.4
New England						
Maine	81.5	92.4	99.1	99.8	99.8	99.8
New Hampshire	56.5	69.9	96.9	99.3	99.4	99.5
Vermont	64.3	94.7	99.1	99.6	99.6	99.7
Massachusetts [1]	93.7	99.5	99.8	99.9	99.9	99.9
Rhode Island	94.0	98.7	99.9	99.9	100.0	100.0
Connecticut	57.6	84.7	97.6	99.9	99.1	99.2
Middle Atlantic						
New York	70.3	81.9	95.6	98.6	98.8	98.9
New Jersey	62.3	73.0	92.6	98.0	98.3	98.6
Pennsylvania	88.1	95.7	99.6	99.8	99.8	99.9
East North Central						
Ohio	50.8	82.6	99.7	99.9	99.9	99.9
Indiana	49.6	77.2	96.5	99.4	99.4	99.5
Illinois	51.7	75.9	98.6	98.8	99.1	99.2
Michigan	88.2	94.5	99.0	99.7	99.7	99.7
Wisconsin	51.7	68.2	94.2	99.4	99.5	99.6
West North Central						
Minnesota	30.6	47.6	86.2	95.7	96.3	96.7
Iowa	46.9	69.8	99.2	99.2	99.3	99.4
Missouri [2]	50.1	74.9	96.7	99.3	99.4	99.4
North Dakota	30.5	55.0	92.9	99.4	99.4	99.5
South Dakota	18.7	39.2	67.0	92.8	93.8	94.9
Nebraska	47.3	64.9	89.6	96.8	97.5	97.9
Kansas [3]	72.7	88.8	97.1	99.6	99.6	99.6
South Atlantic						
Delaware	81.8	90.5	97.8	99.3	99.4	99.5
Maryland [4]	81.6	91.4	98.1	99.2	99.3	99.4
District of Colombia [5]	78.1	87.5	96.6	98.7	98.8	98.9
Virginia [6]	66.4	87.3	98.4	99.6	99.7	99.7
West Virginia	66.7	93.2	99.1	99.6	99.8	99.8
North Carolina	60.3	80.8	96.7	99.0	99.2	99.3
South Carolina	64.9	87.1	97.0	99.4	99.5	99.6
Georgia	63.9	83.5	97.4	99.3	99.4	99.5
Florida	62.2	84.1	98.4	99.5	99.6	99.6
East South Central						
Kentucky	50.3	84.8	97.9	99.5	99.5	99.6
Tennessee	55.6	84.0	98.3	99.6	99.6	99.7
Alabama	74.6	92.3	98.9	99.7	99.8	99.8
Mississippi	63.5	88.1	97.8	99.4	99.6	99.7
West South Central						
Arkansas	72.6	92.0	98.7	99.6	99.7	99.8
Louisiana	51.0	88.0	98.1	99.5	99.6	99.7
Oklahoma	39.0	68.2	94.2	99.1	99.3	99.3
Texas	63.0	79.9	96.6	99.2	99.3	99.4
Mountain						

TABLE 2-33--PHYSICIAN ASSIGNMENT RATES AS PERCENT OF COVERED CHARGES BY STATE, SELECTED YEARS 1985-2002-continued

[In Percent]

Census division/State	1985	1990	1995	2000	2001	2002
Montana	42.6	53.0	86.3	98.6	98.8	99.0
Idaho	25.2	36.1	71.7	90.2	93.4	94.9
Wyoming	33.8	43.9	81.8	93.6	94.5	95.6
Colorado	56.0	70.4	93.5	98.1	98.4	98.7
New Mexico	58.3	76.1	95.2	98.8	99.0	99.1
Arizona	52.8	76.2	92.8	95.0	95.6	96.1
Utah	63.1	80.4	96.6	99.5	99.6	99.7
Nevada	81.6	96.0	99.4	99.8	99.8	99.9
Pacific						
Washington	45.5	54.8	93.4	98.8	99.1	99.3
Oregon	38.7	59.9	92.3	98.2	98.5	98.8
California	71.3	84.4	97.3	99.1	99.3	99.4
Alaska	54.4	79.6	96.2	98.9	99.1	99.2
Hawaii	61.2	82.9	98.7	99.5	99.5	99.5

[1] Massachusetts enacted a Medicare mandatory assignment provision, effective April 1986. The fact that the assignment rates shown here are not 100 percent may be explained by the inclusion in the data base of billings by practitioners other than allopathic and osteopathic physicians, which are included in the Medicare statutory definition of "physician".

[2] Starting with the fiscal year 1993 includes data for all counties in Missouri plus two counties on the State border.

[3] Starting with the fiscal year 1993 includes data for all counties in Kansas excluding two counties on the State border.

[4] Starting with the fiscal year 1993 includes data for all counties in Maryland excluding two counties on the State border.

[5] Starting with the fiscal year 1993 includes data for the District of Columbia plus two counties in Maryland and located on the State border plus a few counties and cities located in Virginia, near the State border.

[6] Starting with the fiscal year 1993 includes data for all counties in Virginia excluding a few counties and cities near the State border.

Source: Centers for Medicare & Medicaid Services.

TABLE 2-34--MEDICARE PHYSICIAN PARTICIPATION RATES: PERCENT OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS WITH AGREEMENTS AND THEIR SHARE OF ALLOWED CHARGES, 1984-2002

Participation Period	Percent of Physicians Signing Agreements	Participating Physicians Covered Charges as a Percent of Total [1]
October 1984-September 1985	30.4	36.0
October 1985-April 1986	28.4	36.3
April 1986-December 1986	28.3	38.7
January 1987-March 1988	30.6	48.1
April 1988-December 1988	37.3	57.9
January1989-March 1990	40.2	62.0
April 1990-December 1990	45.5	67.2
January 1991-December 1991	47.6	72.3
January 1992-December 1992	52.2	78.8
January 1993-December 1993	59.8	85.5
January 1994-December 1994	64.8	89.4
January 1995-December 1995	72.3	92.6
January 1996-December 1996	77.5	94.3
January 1997-December 1997	80.2	95.1
January 1998-December 1998	82.8	95.7
January 1999-December 1999	84.6	95.9

TABLE 2-34--MEDICARE PHYSICIAN PARTICIPATION RATES: PERCENT OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS WITH AGREEMENTS AND THEIR SHARE OF ALLOWED CHARGES, 1984-2002-continued

Participation Period	Percent of Physicians Signing Agreements	Participating Physicians Covered Charges as a Percent of Total [1]
January 2000-December 2000	88.3	96.2
January 2001-December 2001	88.7	96.4
January 2002-December 2002	89.7	96.7

[1] Rates reflect covered charges for physician services processed during period.

[2] The actual participation period was May through December of 1986, and participation agreements were in effect at that time. However, charge data are generally collected by quarter; thus, the data for the last three quarters of 1986 are used as a proxy for the participation period.

Source: Centers for Medicare & Medicaid Services.

TABLE 2-35--PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS, BY SPECIALTY FOR SELECTED PARTICIPATION PERIODS, 1990-2002[1]

	1990	1995	2000	2001	2002
Physicians (M.D.s and D.O.s):					
General practice	39.7	59.9	80.2	79.0	81.4
General surgery	55.8	80.2	93.3	92.5	93.0
Otology, laryngology, rhinology	45.2	77.1	91.8	91.3	92.1
Anesthesiology	30.8	73.9	93.7	92.3	92.8
Cardiovascular Disease	60.6	84.9	95.8	94.4	94.8
Dermatology	53.4	79.3	90.8	90.1	90.5
Family Practice	47.2	74.5	90.8	90.3	91.2
Internal Medicine	48.8	73.8	90.7	88.7	89.3
Neurology	53.1	78.9	92.1	89.9	90.5
Obstetrics-gynecology	48.8	72.5	86.8	86.3	86.9
Ophthalmology	55.6	81.2	93.3	92.8	93.6
Orthopedic surgery	53.7	82.6	93.8	93.1	93.6
Pathology	53.4	78.9	93.6	92.2	92.5
Psychiatry	41.6	58.7	79.1	79.6	80.8
Radiology	55.6	82.8	95.3	91.9	92.5
Urology	49.6	83.0	94.6	93.8	93.6
Nephrology	66.5	87.0	95.1	93.6	94.0
Clinic/other grp practice-not GPPP	68.7	79.4	91.6	92.7	93.5
Limited license practitioners (LLP):					
Chiropractor	26.2	42.6	59.4	63.0	64.5
Podiatry-surgical chiropody	54.0	79.2	90.7	91.6	92.3
Optometrist	54.0	66.9	78.4	80.0	80.9

[1] 1990 is for April-December; all other years January-December.

Note-Effective with the October 1, 1985 election period, carriers were instructed to count individuals only once, even if practicing in multiple settings.

Source: CMS/OFM.

TABLE 2-36--PHYSICIAN AND LIMITED LICENSED PRACTITIONER PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS, BY STATE, FOR SELECTED PARTICIPATION PERIODS 1985-2002

State	October 1985-April 1986	1991	1995	2000	2001	2002
Alabama	58.2	82.7	90.5	95.5	96.0	96.1
Alaska	10.4	53.8	77.1	82.9	83.7	86.1
Arizona	15.4	61.3	87.1	90.3	88.5	90.6
Arkansas	45.2	59.9	74.8	94.6	95.1	95.5
California	30.0	60.8	74.5	85.5	78.5	78.6
Colorado	28.1	35.3	65.2	87.4	88.4	89.5
Connecticut	22.2	29.3	57.8	89.3	89.9	90.5
Delaware	23.9	43.9	68.0	85.2	86.9	92.0
District of Columbia	30.5	39.8	63.0	84.1	85.2	90.8
Florida	25.7	36.5	68.0	90.1	92.1	92.9
Georgia	33.1	53.6	86.3	89.4	89.5	90.8
Hawaii	20.6	57.3	82.8	90.3	91.0	94.3
Idaho	11.0	19.5	54.7	77.6	79.4	80.8
Illinois	23.1	46.9	73.3	90.9	92.4	92.6
Indiana	18.2	45.1	72.8	83.2	85.1	85.5
Iowa	29.7	51.9	81.1	93.2	94.0	94.2
Kansas	45.4	62.6	84.4	94.2	94.4	94.6
Kentucky	24.3	59.5	83.4	93.8	93.3	93.7
Louisiana	18.8	42.9	57.4	91.7	92.1	92.3
Maine	35.4	50.3	68.9	94.3	93.6	93.7
Maryland	30.4	45.3	88.1	93.4	94.2	94.1
Massachusetts	48.1	50.8	64.7	94.9	91.7	92.1
Michigan	44.0	53.7	75.3	95.3	96.6	96.9
Minnesota	18.5	29.3	58.6	79.3	79.9	80.4
Mississippi	19.1	42.7	59.4	83.5	84.6	85.6
Missouri	35.2	49.0	87.6	87.9	90.0	95.6
Montana	24.3	24.8	70.1	86.6	88.6	89.9
Nebraska	20.0	56.5	82.5	92.7	93.2	93.8
Nevada	21.7	72.9	91.2	94.1	91.2	96.2
New Hampshire	26.9	32.7	60.4	93.1	90.8	91.1
New Jersey	18.0	29.6	54.9	82.8	84.5	87.4
New Mexico	17.7	49.7	78.1	89.9	91.1	92.6
New York	20.8	34.6	59.2	80.3	81.0	81.2
North Carolina	39.1	58.1	77.6	89.6	90.0	91.1
North Dakota	10.9	43.9	81.8	95.5	96.3	97.2
Ohio	21.7	52.5	90.5	93.9	94.2	95.5
Oklahoma	13.8	39.0	72.3	91.7	92.5	93.9
Oregon	18.5	46.7	79.7	90.7	91.2	92.8
Pennsylvania	50.8	45.9	67.3	85.5	94.3	95.8
Rhode Island	46.7	67.8	80.9	72.5	74.1	75.6
South Carolina	17.9	57.9	76.1	91.4	91.5	92.1
South Dakota	8.0	20.6	51.7	86.7	87.7	89.3
Tennessee	21.1	63.7	80.6	91.2	91.3	92.2
Texas	19.7	38.9	76.9	85.4	86.5	88.0

TABLE 2-36--PHYSICIAN AND LIMITED LICENSED PRACTITIONER PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS, BY STATE, FOR SELECTED PARTICIPATION PERIODS 1985-2002-continued

State	October 1985-April 1986	1991	1995	2000	2001	2002
Utah	29.3	65.6	85.9	94.6	95.1	96.2
Vermont	41.5	45.4	68.8	92.9	94.8	94.9
Virginia	29.6	48.1	55.6	87.3	87.6	88.6
Washington	23.6	46.1	76.2	92.9	93.8	96.2
West Virginia	22.9	66.3	87.2	93.5	94.2	94.8
Wisconsin	31.0	46.8	81.2	90.9	92.7	94.5
Wyoming	18.3	39.1	66.4	87.1	87.3	87.7
National	28.4	47.6	72.3	88.3	88.7	89.7

Note-Other practitioners includes limited license practitioners and non-physician practitioners.
Source: CMS/OFM.

NONPHYSICIAN PRACTITIONER SERVICES

Medicare covers certain services provided by nonphysician practitioners such as nurse practitioners and physician assistants. These practitioners are paid under the physician fee schedule and are required to accept assignment on all claims. Nonphysician practitioners are different from limited licensed practitioners (such as podiatrists and chiropractors) who have the option of whether or not to accept assignment.

Physician Assistants and Nurse Practitioners

Separate payments are made for physician assistant services, when provided under the supervision of a physician. Separate payments are also made for nurse practitioner services, provided in collaboration with a physician. Payment for these services can only be made if no facility or other provider charges are paid in connection with the service. Payment equals 80 percent of the lesser of either the actual charge or 85 percent of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment equals 80 percent of the lesser of either the actual charge or 85 percent of the amount that would have been recognized for a physician serving as an assistant- at-surgery. The physician assistant may be in an independent contractor relationship with the physician.

Certified Nurse Midwife Services

Certified nurse midwife services are paid at 65 percent of the physician fee schedule amount.

Certified Registered Nurse Anesthetists

Certified registered nurse anesthetists are paid under the same fee schedule used for anesthesiologists (see above). Payments for services furnished by an anesthesia care team composed of an anesthesiologist and a certified registered

nurse anesthetist are capped at 100 percent of the amount that would be paid if the anesthesiologist were practicing alone. The payments are evenly split between each practitioner.

Clinical Psychologists and Clinical Social Workers

Diagnostic and therapeutic services provided by clinical psychologists are paid under the physician fee schedule. Payments for services provided by clinical social workers are equal to 75 percent of the amount allowed for clinical psychologists. Some services are subject to the psychiatric services limitation which limits Medicare payments for some services to 50 percent of incurred expenses.

Physical or Occupational Therapists

Payments for physical therapy and occupational therapy services are made under the physician fee schedule. 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 (OPD). A separate $1,500 limit applied to all outpatient occupational therapy services except for those furnished by hospital OPDs. Therapy services furnished as incident to physicians' professional services were included in these limits. The $1,500 limits were to apply each year, with updates for inflation beginning in 2002. However, BBRA 1999 suspended application of these limits in 2000 and 2001 and BIPA suspended application in 2002. Thus, no limits applied in these 3 years. CMS implemented the limit $1,590 (reflecting inflation updates) September 1, 2003.

CLINICAL LABORATORY SERVICES

Coverage

Medicare provides coverage for diagnostic clinical laboratory services. These services may be provided by an independent laboratory, a physician's office laboratory, or a hospital laboratory to outpatients. Laboratories must meet the requirements of the Clinical Laboratory Improvement Act Amendments of 1988. This legislation, which focused on the quality and reliability of medical tests, expanded Federal oversight to virtually all laboratories in the country, including physician office laboratories.

BBA 1997 required the Secretary to adopt uniform coverage policies for laboratory tests using a negotiated rulemaking process. The policies would be designed to eliminate variation among carriers and to simplify administrative requirements. A final rule detailing national coverage and administrative policies for labs paid under Part B was published on November 23, 2001. It was effective November 25, 2002, except that labs could request up to an additional 12 months to make the necessary changes to their computer systems.

The rule establishes 23 national coverage determinations (NCDs) for the most commonly ordered lab tests. For each of the 23 clinical diagnosis lab service

NCDs listed in the final rule, there is a list of current procedural technology (CPT) codes identifying the test, panel of tests, or group of tests covered under the NCD. In addition, for each NCD there are 3 lists of diagnosis codes, known as ICD-9-CM codes (International Classification of Diseases, Ninth Revision, Clinical Modification). The first list, "ICD-9-CM codes covered by Medicare" includes codes where there is a presumption of medical necessity, though the claim may be subject to review. The second list, "ICD-9-CM codes denied," includes lists of codes that are never covered. The third list, "ICD-9-CM codes that do not support medical necessity" include diagnoses that generally are not covered for the test, but for which there are limited exceptions. Additional documentation could support a determination of medical necessity in certain cases. For each of the 23 NCDs, each ICD-9-CM code falls into one of the 3 ICD-9-CM lists.

Payment

Since 1984, Medicare has paid for clinical laboratory services on the basis of a fee schedule. Fee schedules have been established on a carrier service area basis. The law set the initial payment amount for services performed in physicians' offices or independent laboratories at the 60th percentile of the prevailing charge established for the 12-month period beginning July 1, 1984. Similarly, the initial fee schedule payment amount for services provided by hospital-based laboratories serving hospital outpatients was set at the 62d percentile of the prevailing charge level. Subsequent amendments to the payment rules limited application of the hospital fee schedule to "qualified hospitals." A qualified hospital is a sole community hospital (as that term is used for payment purposes under Medicare's hospital inpatient prospective payment system (IPPS)) which provides some clinical diagnostic tests 24 hours a day in order to serve a hospital emergency room which is available to provide services 24 hours a day, 7 days a week.

Payments under the fee schedule equal the lesser of the actual charge billed for the test, the local fee or the national limitation amount (NLA). For tests for which NLAs were set before 2001, the NLA is 74 percent of the median of local fees. For tests for which NLAs are first established after such date, the NLA is 100 percent of the median of the local fees. A national minimum payment amount is established for Pap smears; in 2003, this minimum payment is $14.76.

The fee schedule payment amounts have been increased periodically since 1984 to account for inflation. The updates have generally occurred on January 1 of each year. BBA 97 eliminated the updates for 1998-2002. The update for 2003 is 1.1 percent.

Payment for clinical laboratory services (except for those provided by a rural health clinic) may only be made on the basis of assignment. Payment for clinical laboratory services equals 100 percent of the fee schedule amount; no beneficiary cost sharing is imposed.

DURABLE MEDICAL EQUIPMENT AND PROSTHETICS AND ORTHOTICS

Medicare Part B covers a wide variety of medical supplies if they are medically necessary and are prescribed by a physician. Under the program, durable medical equipment (DME) includes such items as hospital beds, blood glucose monitors, and wheelchairs. The benefit also includes related supplies, such as drugs and biologicals that are necessary for the effective use of the product. Guidelines define DME as equipment that: (1) can withstand repeated use; (2) is used to serve a medical purpose; (3) generally is not useful in the absence of an illness or injury; and (4) is appropriate for use in the home. All of these requirements must be met before an item can be covered.

Medicare also covers prosthetic devices. These are defined as items that replace all or part of an internal body organ, such as colostomy bags, pacemakers, and breast prostheses for postmastectomy patients. Prosthetics and orthotics include such items as leg, arm, back and neck braces, and artificial legs, arms, and eyes.

Reimbursement for durable medical equipment

Medicare pays for DME on the basis of a fee schedule originally established by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). Under the DME fee schedule, Medicare pays 80 percent of the lower of either the item's actual charge or the fee schedule amount. The beneficiary is responsible for the remaining 20 percent. Under the fee schedule, covered DME items are classified into five groups: (1) inexpensive or routinely purchased DME; (2) items requiring frequent and substantial servicing; (3) customized items (equipment constructed or modified substantially to meet the needs of an individual patient); (4) other items of DME (frequently referred to as the "capped rental" category); and (5) oxygen and oxygen equipment. Some items that do not meet the definition of DME, such as disposable surgical dressings, are also covered under the fee schedule.

In general, the fee schedule payment rates for DME are determined locally (on a statewide basis). However, these local payments are subject to floor and ceiling limits determined nationally. Medicare will not pay less than 85 percent of the weighted average of all local payment amounts (floor), and will not pay more than 100 percent of this average (ceiling).

Prosthetics and orthotics are also paid according to a fee schedule similar to the DME fee schedule. The payment rates are determined regionally (there are 10 regions) and are subject to national limits which also have ceilings and floors. The floor is 90 percent of the weighted average of all regional payment amounts, and the ceiling is 120 percent of this weighted average.

The fee schedules are generally updated annually by the CPI–U. However, BBA 1997 eliminated updates for DME for fiscal years 1998–2002. In 2003, the update returned to the CPI-U. The update for prosthetics and orthotics was limited to 1.0 percent through fiscal year 2002. Subsequent legislation temporarily restored payment updates. For oxygen and oxygen equipment, BBA 1997 set the national

payment limits beginning in fiscal year 1999 to 70 percent of 1997 levels.

Medicare pays for a few items of medical equipment on a reasonable cost basis, rather than under the fee schedule. These include medical supplies; home dialysis equipment; therapeutic shoes; parenteral and enteral nutrients (PEN), equipment, and supplies; transfusion medicine; and blood products. BBA 1997 authorized the Secretary to establish fee schedules for these items. The final regulation, issued August 2001, however, established a fee schedule only for PEN. Its amounts are based on the reasonable charges that would have been used in 2002. It will be updated by the CPI-U.

Table 2-37 shows total Medicare spending in calendar year 2001 for DME, prosthetics and orthotics, and certain other items.

TABLE 2-37--MEDICARE SPENDING FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND CERTAIN OTHER ITEMS, CALENDAR YEAR 2001

Category	Medicare Spending
Surgical Dressings	$37,740,571
Supplies/Accessories	$327,272,640
Capped Rental	$1,537,862,990
Customized Items	$49,339
Oxygen	$1,959,620,305
Prosthetics/Orthotics	$933,570,890
Inexpensive/Routine	$1,066,078,939
Items w/Frequent Maint.	$133,180,137
Other	$163,926,394
Parental/Enteral	$719,725,080
DME to Admin Drugs	$847,894,411
Total	$7,726,921,696

Source: Centers for Medicare & Medicaid Services.

Inherent reasonableness authority--If the Secretary determines that using standard procedures to calculate payment for an item under the fee schedule results in an amount which is "grossly excessive or grossly deficient and not inherently reasonable," the Secretary is authorized to increase or decrease the payment amount accordingly. The authority to make these adjustments is generally referred to as the inherent reasonableness authority. It involves a complex procedure of investigation, commentary, and notification.

BBA 1997 sought to simplify the procedure and widen the application of this authority, requiring that new criteria be established for determining if a fee schedule charge was inherently unreasonable, and the factors to be used in determining charges that are realistic and equitable. Using these criteria, the Secretary would be permitted to adjust payment levels. An interim final rule was issued in December 2002. Significantly, the rule states that the inherent reasonableness authority will not be used in situations where there is less than a 15 percent difference between the current payment rate and a proposed payment rate.

Administering the DME benefit

CMS enters into contracts with insurance companies known as carriers under Part B of Medicare, to administer the program, i.e., to process claims and make payments. In the case of DME, administration is centralized in four regional carriers (known as DME regional carriers, or DMERCs) who are responsible for processing claims for all beneficiaries living within their areas. As a result of the consolidation, which occurred in 1992, variation in coverage policy and utilization patterns has been reduced. Suppliers provide Medicare beneficiaries with medical equipment and bill the regional carrier in their area. Before being issued a Medicare supplier number, suppliers must comply with various standards, including maintaining a physical location, being responsible for deliveries to beneficiaries and honoring all product warranties, and providing proof of appropriate liability insurance.

Competitive bidding

Investigations have shown that Medicare pays higher prices for certain medical supplies than those paid by other health care insurers and other government agencies, including the Department of Veterans Affairs. BBA 1997 provided authority for Medicare to establish five 3-year demonstration projects under which suppliers competitively bid for contracts to deliver specific items of DME to beneficiaries. The first project was established in 1999 in Polk County, Florida. Suppliers submitted bids, competing for the right to provide certain medical equipment to the 92,000 Medicare beneficiaries in the area. Bids were evaluated on the basis of quality and price. Numerous suppliers were chosen for each item to maintain beneficiary access. The demonstration project ended September 2002. A second demonstration project began operations in San Antonio, Texas, in February 2001, where approximately 112,000 Medicare beneficiaries were involved. That project terminated in December 2002. CMS estimated that competitive bidding in the two projects resulted in overall savings of approximately 19.9 percent over fee schedule prices.

HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Table 2-38 summarizes the history of Medicare payments for hospital outpatient services from 1974 through 2001. Medicare payments increased almost 55-fold, from $323 million in 1974 to $17.7 billion in 2001, with annual rates of increase averaging as high as 26.5 percent from 1974 to 1984, falling to 13.3 percent from 1984 to1994. Most recently, from 1995 to 2001, the annual rate of change has been 5.4 percent per year. The substantial rates of increase in OPD payments per Part B enrollee (from $14 in 1974 to $563 in 2001) reflect the increase in the volume of services provided in OPDs as well as growth in payments for those services under the retrospective cost-based payment system. Since 1974, hospital charges for outpatient services provided to Medicare beneficiaries increased by almost 20 percent per year, on average. Medicare's payments for OPD services increased by 16 percent per year during that time period. Medicare's

payments for covered OPD services as a proportion of hospital charges has declined from nearly 70 percent in 1983 to 25 percent in 2001. This declining ratio reflects primarily the high rates of increase in hospital charges and, to a lesser extent, limits on the rate of increase in Medicare's payments for outpatient services due to fee schedules and blended payment formulas.

TABLE 2-38--MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENTS BY TYPE OF ENROLLMENT AND YEAR OF SERVICE, SELECTED YEARS 1974-2001

Year of Service	Number of SMI [1] Enrollees (In Thousands)	Charges for Covered Services (In Thousands)	Program Payments		
			Amount (In Thousands)	Per Enrollee	Percent of Covered Charges
			All Enrollees		
1974	23,166,570	$535,296	$323,383	$14	60.4
1980	27,399,658	2,076,396	1,441,986	52	69.4
1984	29,415,397	5,129,210	3,387,146	115	66.0
1985	29,988,763	6,480,777	4,082,303	136	63.0
1990	32,635,800	18,346,471	8,171,088	250	44.5
1991	33,239,840	22,016,673	8,612,320	259	39.1
1992	33,956,460	26,799,501	9,941,391	293	37.1
1993	34,642,500	32,026,576	10,938,545	316	34.2
1994	35,178,600	36,323,649	11,813,522	336	32.6
1995 [2]	31,806,740	40,476,180	12,933,358	407	31.9
1996	31,775,280	44,564,665	13,896,048	437	31.2
1997	31,022,040	47,888,129	14,382,561	464	30.0
1998	30,304,340	50,607,564	14,212,983	469	28.1
1999	30,083,220	54,744,210	14,617,464	486	26.7
2000	30,477,540	60,728,234	14,969,335	491	24.6
2001	31,513,140	71,066,998	17,739,919	563	25.0
		Average Annual Rate of Growth			
1974-2001	1.1	19.8	16.0	14.7	--
1974-1984	2.4	25.4	26.5	23.4	--
1984-1994	1.8	21.6	13.3	11.3	--
1995-2001	-0.2	9.8	5.4	5.6	--
			Aged		
1974	21,421,545	394,680	220,742	10	55.9
1980	24,680,432	1,517,183	1,030,896	42	69.9
1984	26,764,150	4,122,859	2,679,571	100	65.0
1985	27,310,894	5,210,762	3,211,744	118	61.6
1990	29,691,180	15,384,510	6,563,454	221	42.7
1991	30,183,480	18,460,835	6,842,329	227	37.1
1992	30,722,080	22,253,657	7,741,774	252	34.8
1993	31,162,480	26,556,415	8,522,089	273	32.1
1994	31,443,800	29,768,892	9,116,610	290	30.6
1995 [2]	28,020,760	33,110,441	9,900,199	353	29.9
1996	27,849,640	36,099,678	10,542,937	379	29.2
1997	27,046,120	38,728,484	10,861,323	402	28.0
1998	26,243,140	41,945,972	10,681,369	407	26.0
1999	25,918,800	44,272,508	10,903,014	421	24.6

TABLE 2-38--MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENTS BY TYPE OF ENROLLMENT AND YEAR OF SERVICE, SELECTED YEARS 1974-2001-continued

Year of Service	Number of SMI [1] Enrollees (In Thousands)	Charges for Covered Services (In Thousands)	Program Payments		
			Amount (In Thousands)	Per Enrollee	Percent of Covered Charges
2000	26,173,700	48,940,902	11,029,355	421	22.5
2001	26,974,140	57,262,254	13,142,167	487	23.0
Average Annual Rate of Growth					
1974-2001	0.9	20.2	16.3	15.5	--
1974-1984	2.3	26.4	28.4	25.9	--
1984-1994	1.6	21.9	13.0	11.2	
1995-2001	-0.6	9.6	4.8	5.5	--
Disabled					
1974	1,745,019	140,617	102,641	59	73.0
1980	2,719,226	559,213	411,090	152	73.5
1984	2,651,247	1,006,351	707,575	267	70.3
1985	2,677,869	1,270,015	870,560	325	68.5
1990	2,944,620	2,961,961	1,607,634	546	54.3
1991	3,056,360	3,555,838	1,769,991	579	49.8
1992	3,234,380	4,545,843	2,199,617	680	48.4
1993	3,480,020	5,470,161	2,416,456	694	44.2
1994	3,734,800	6,463,757	2,696,912	722	41.7
1995 [2]	3,785,980	7,465,739	3,033,158	801	40.6
1996	3,925,640	8,464,987	3,353,211	854	39.6
1997	3,975,920	9,159,645	3,521,238	886	38.4
1998	4,061,200	9,561,592	3,531,614	870	36.9
1999	4,164,420	10,471,702	3,714,450	892	35.5
2000	4,303,840	11,787,331	3,939,980	915	33.4
2001	4,303,840	13,804,744	4,597,752	1,013	33.3
Average Annual Rate of Growth					
1974-2000	3.6	18.5	15.1	11.1	--
1974-1984	4.3	21.8	21.3	16.3	--
1984-1994	3.5	20.4	14.3	10.5	
1995-2001	3.1	10.8	7.2	4.0	--

[1] 1974 is the first full year of coverage for disabled beneficiaries under Medicare.

[2] Beginning in 1995, the utilization rates per 1,000 enrollees do not reflect managed care enrollment; that is, Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates.

Note: Numbers may not add to totals because of rounding. Hospital outpatient services include clinics or hospital-based renal dialysis facility services, and surgical facility or hospital-based ambulatory surgical center services provided to hospital outpatient

Source: Centers for Medicare & Medicaid Services, Office of Research, Development and Information

As Table 2-39 shows, although the number of hospitals has fallen over past decade (from 5,191 in 1991 to 4,347 in 2001), the proportion of these hospitals that offer outpatient surgery and emergency services has increased. Almost all hospitals provide outpatient services and a significant percentage provide outpatient surgery.

TABLE 2-39--PROVIDERS OF HOSPITAL OUTPATIENT SERVICES, SELECTED YEARS 1991-2001

Year	Number of hospitals	Percentage offering		
		Outpatient Services	Outpatient Surgery	Emergency Services
1991	5,191	92	79	91
1997	4,976	93	81	92
2001	4,347	94	84	93

Note: Excludes long-term and alcohol and drug abuse hospitals.

Source: MedPAC analysis of Medicare provider of service file.

Medicare beneficiaries receive a wide range of services in hospital outpatient departments (HOPD), from injections to surgical procedures under general anesthesia. Services provided in HOPDs which are paid under Medicare Part B include: (1) emergency room and clinic services; (2) operating and recovery room services; (3) laboratory and pharmacy services; (4) physical therapy and rehabilitation services; (5) DME; and (6) chemotherapy and radiation therapy. HOPDs also provide diagnostic and preventive procedures such as radiology, computer axial tomography (CAT) scans, magnetic resonance imaging, endoscopies, and colonoscopies. Table 2-40 shows the percent distribution of HOPD charges by type of service provided to Medicare beneficiaries in 2001. Radiology and laboratory services comprise about a third of the total hospital outpatient charges.

TABLE 2-40--PERCENT DISTRIBUTION OF HOSPITAL OUTPATIENT DEPARTMENT CHARGES UNDER MEDICARE, BY TYPE OF SERVICE, 2001

Service	Percent of Charges
Radiology	21.6
Laboratory	12.5
Operating Room	11.5
End-Stage Renal Disease	5.8
Pharmacy	4.2
Emergency Room	4.0
Clinic	1.5
Rehabilitation	2.3
Medical/Surgical Supplies	8.1
All Other[1]	28.5

[1] Includes computerized axial tomography, durable medical equipment, blood, and so forth.

Source: Centers for Medicare & Medicaid Services, Office of Research, Development and Information.

In 2001, about 62 percent of the Medicare beneficiaries that received fee-for-service Medicare used hospital outpatient services; about 150 million outpatient services were paid for under the outpatient prospective payment system (OPPS) implemented in short-term general hospitals. In 2001, the first full year of the new outpatient payment system, OPPS spending was $18.4 billion, including

$10.4 billion by the program and $8.0 billion in beneficiary cost sharing. In 2001, beneficiary cost sharing (which has historically been higher for hospital outpatient services than the typical 20 percent cost sharing for other Part B services) was about 42 percent of total payments.

Background

In the early years of the Medicare program, Medicare paid for both inpatient and outpatient hospital care based on a hospital's reasonable costs attributable to providing covered services for Medicare beneficiaries. Using these retrospective payment systems, Medicare paid the allowable costs incurred in providing care, the amount of which was determined and made after the service was rendered. Medicare's payment systems for hospital inpatient care and outpatient services were separated in 1983 when a new prospective system was implemented for inpatient care. Under that arrangement, a hospital receives a fixed payment, known in advance of providing care, covering all care and services required by a patient during a hospital stay (exclusive of physician fees) and determined by the diagnosis-related group (DRG) into which the patient is classified at admission. However, outpatient services remained under the costs-or-charges retrospective payment arrangement. Throughout the 1980s, Medicare payments for hospital outpatient services grew as the volume of services provided in that setting increased. Although growth in the Medicare population contributed to increased utilization of outpatient care, a substantial share of the growth in the volume of outpatient services is attributable to advances in medicine and technology that permit procedures formerly restricted to the inpatient hospital setting to be provided safely on an outpatient basis. Aggressive management of inpatient utilization attributed to the incentives inherent in the IPPS payment system may also have influenced the shift in care from hospital inpatient to hospital outpatient departments. Outpatient services have become an important revenue source for hospitals; outpatient revenue is relatively more important to rural than to urban hospitals.

Since the early 1980s, Medicare's payments for HOPD services have grown for reasons other than increased volume, and that growth is often attributed to the lack of incentives for efficiency or cost control inherent in the retrospective cost-based payment system. Congress sought to contain the rate of increase in Medicare payments for certain outpatient services by requiring implementation of fee schedules to pay for those services. For example, Congress required the Health Care Financing Administration (HCFA, now called the Centers for Medicare & Medicaid Services, or CMS) to establish fee schedules for many outpatient diagnostic laboratory procedures and tests; for orthotics, prosthetics, and DME; dialysis for persons with end-stage renal disease (ESRD); and surgeries that might also take place in another outpatient setting such as ambulatory surgical centers (ASCs). In the Omnibus Budget Reconciliation Acts of 1986 and 1990, Congress directed the Secretary of Health and Human Services (the Secretary) to develop a PPS for all HOPD care. In addition, to achieve more immediate savings, legislation required across-the-board reductions in Medicare payments for hospital operating

costs and capital costs (including those associated with outpatient care) starting in 1990.

Over time, a fairly complex set of Medicare payment rules for outpatient hospital services evolved. Although Medicare implemented fee schedules for some HOPD services, payment for other services remained under the retrospective payment system. For instance, payments for clinic and emergency room visits were paid based on the lesser of a hospital's reasonable costs or customary charges. Certain surgeries carried out in the HOPDs, but which are also approved by Medicare to be provided in ASCs were paid the lower of costs, charges, or a blended payment that incorporated the ASC fee schedule amount (again, excluding physicians service which are paid separately). Payment for certain radiology services and diagnostic procedures were based on a blended payment that included, in part, the Medicare fee schedule for physician services. Moreover, these blended payment calculations varied among different types of hospitals.

The calculation of a beneficiary's coinsurance amount was similarly complex. A beneficiary's coinsurance payment was calculated based on 20 percent of the hospital's charges for those services where Medicare's payment was based on 80 percent of the lower of reasonable costs or customary charges. For most services, Medicare's payment was offset by the beneficiary's payment, so that hospitals were not paid more than 100 percent of the Medicare approved amount. Over time, as charges for hospital outpatient services increased faster than hospital costs (and Medicare's payments), beneficiaries' coinsurance payments began to represent a larger and larger share of total payments to hospitals for outpatient services. Also, for certain services, such as ASC approved surgical procedures, Medicare's program payment was not fully reduced by the beneficiary's coinsurance payment; hospitals received payments that were greater than the Medicare approved amount. These formula driven overpayments (FDOs) were estimated to be approximately $850 million by industry representatives at the time of implementation of OPPS.

Despite implementation of fee schedules, blended payment amounts, and across-the-board reductions in payments, Medicare HOPD payments rose at an annual rate of over 12 percent from 1983 to 1997 and increased from 7 percent to 20 percent as a share of all Medicare payments to hospitals. Many saw the patchwork payment arrangements for outpatient services as fraught with disincentives for hospitals to provide care efficiently. Accordingly, BBA 1997 extended the across-the-board reductions of 5.8 percent for operating costs and 10 percent for capital costs through 1999 and directed the Secretary to implement OPPS in 1999. BBA 1997 also eliminated the formula-driven overpayment, effective at the start of FY1998, a move that resulted in an almost immediate reduction in payments to hospitals. The legislation established a buy-down procedure to reduce beneficiary cost sharing for OPD services gradually to 20 percent of Medicare approved amounts. Beneficiary coinsurance would be established at 20 percent of the median of all hospital outpatient charges per procedure in 1996, updated to the time of implementation of OPPS and "frozen" at those dollar amounts. Over time, as Medicare's program payments under the new

OPPS increase with beneficiary payments frozen, the beneficiary payment amounts would come to equal 20 percent of Medicare's PPS payments. However, the buy down for those services where the difference between the median charge and the PPS approved amount is large could take decades. Under BBA 1997, hospitals were permitted to limit beneficiary copayments to 20 percent voluntarily as well as disseminate information regarding their reduced beneficiary charges.

The proposed OPPS regulations were published on September 8, 1998, for public comment with implementation of the new payment system scheduled for implementation in 1999. Implementation of the changes were delayed until after the start of the year 2000 in order to accommodate resolution of Y2K data processing problems. In the meantime significant legislative changes to OPPS were enacted. The Balanced Budget Refinement Act (BBRA) required the implementation of: (1) budget neutral outlier payments, within specified limits, for certain high cost patients; (2) budget neutral pass-through payments for certain new and innovative high cost devices, drugs, and biologicals for 2-3 years; (3) a "2 times" rule which limits the cost range of items or services that are included in any one APC (or ambulatory payment classification which is the classification system for outpatient services described subsequently) so that the highest cost item or service in the group cannot be more than two times higher than the lowest cost item or service within the group; (4) an annual review and update of the APCs and relative weights; (5) transitional corridors through 2003 which phase-in reductions in aggregate Medicare payments that individual hospitals experience due to OPPS implementation; (6) special ``hold harmless'' payments, for small, rural hospitals until January 1, 2004, to ensure that they receive no less under OPPS than they would have received in aggregate under the prior payment system; (7) permanent hold harmless payments for cancer hospitals; (8) a limit on beneficiary copayments for HOPD care set at the annual beneficiary deductible for inpatient care; (9) a budget neutrality benchmark for Medicare spending that includes beneficiary coinsurance amounts paid under the prior system; (10) coverage of the cost of implantable items; (11) use of either the mean or the median of hospital costs when establishing relative APC weights; (12) across-the-board reductions in payments for hospital operating costs and capital costs until implementation of OPPS; and (13) use of the IPPS wage index that accounts for hospitals' reclassification to different geographic areas. Medicare's hospital outpatient payment system was subsequently modified by BIPA to include: (1) scheduled reductions to beneficiary's coinsurance payments from 2002 through 2006 until the maximum rate is 40 percent in 2006; (2) an increase in the 2001 update to the full increase in the market basket as well as other increases to the 2001 OPPS rates; (3) appropriate adjustments to the conversion factor in later years to eliminate the effect of coding or classification changes; (4) modifications to the procedures and standards by which certain medical devices are categorized and determined eligible for pass-through payments under the OPPS; and (5) a permanent hold harmless provision for children's hospitals. Implementation of OPPS began August 1, 2000.

Medicare's hospital outpatient payment system

The OPPS payment is intended to cover hospitals' operating and capital costs for the facility services that are furnished. Under OPPS, the unit of payment is the individual service or procedure as assigned to one of about 570 ambulatory payment classification groups (APCs). Services are classified into APCs based on their Healthcare Common Procedure Coding System (HCPCS), a standardized coding system used to identify products, supplies, and services for claims processing and payment purposes. Some new services are assigned to certain "new technology" APCs based only on similarity of resource use. Individual outpatient services that are similar clinically and comparable in terms of resource utilization are arranged into groups according to an APC system. To the extent possible, integral services and items are bundled within each APC; for example, an APC for a surgical procedure will include operating and recovery room services, anesthesia, and surgical supplies. Each APC has a status indicator to identify which particular OPPS payment policy is applicable. For instance, payments for those APCs with a status indicator of "T" are reduced if multiple procedures are performed on the same visit; payments for those APCs with a status indicator of "S" are not reduced if multiple procedures are performed.

Medicare's payment for these services is calculated by multiplying the relative weight associated with an APC by a conversion factor. A relative value is established for each group and is the same for each service assigned to the group. Except for the new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. The CY2003 APC relative weight calculation used selected claims from April 1, 2001 through March 31, 2002. CMS converted billed charges to costs using cost-to-charge ratios by cost centers specific to each hospital. Data from claims with single or multiple procedure codes were aggregated differently to establish the median cost for each APC. The median costs of each APC was scaled to the median cost associated with APC 0601, the mid-level clinic visit. The relative weights for those APCs that significantly decreased from 2002 to 2003 were subject to a dampening calculation; the decrease was limited to 15 percent plus half the difference of the remaining change from 2002 to 2003.

New Technology APCs--In contrast to other APC groups, services are assigned to the new technology APCs based on their expected costs; the groups do not account for clinical aspects of its packaged services. There are 17 new technology APCs that range from $0-$50 to $5,000 to $6,000, with an additional category at $19,500-$20,500. The relative weights for these APCs are set at the midpoint of the range. Services are included in the new technology APCs for at least 2 years, but no more than 3 years. To be considered for assignment into one of these APCs, the technology must be a complete service or procedure that cannot be adequately described by an existing payment category. The covered service must be new and ineligible for an additional transitional pass-through payment that is described subsequently. Spending in these new technology APCs are not subject to a budget neutrality limit.

Like other Part B fee schedules, the conversion factor translates the relative weights into dollar payment amounts. The conversion factor for 2003 is $52.151. For most APCs, the conversion factor is adjusted to account for geographic variations in cost. The labor related portion (60 percent) of the conversion factor is adjusted by the IPPS wage index accounting for hospital's geographic reclassifications. The conversion factor is updated on a calendar year schedule and the annual updates are based on the hospital market basket (MB) offset by mandated budget neutrality factors associated with wage-index changes, changes to APC groups, and the APC relative weights. Currently, the 2003 HOPD update was the projected change in the hospital inpatient MB of 3.5 percent adjusted by a budget neutrality factor of 0.98715.

Medicare's outpatient PPS includes budget neutral case level adjustments including pass-through payments for new technology and outlier payments for high-cost services. Transitional corridor payments that limit hospitals' losses under OPPS have been established through 2003 as well. Small rural hospitals with 100 or fewer beds have such protections through 2003. Also, permanent hold harmless payments for cancer, and children's hospitals have been established.

Transitional pass-through payments for new technology--Transitional pass-through payments are supplemental payments to cover the incremental cost associated with certain medical devices, drugs and biologicals that are inputs to an existing service. The additional payment for a given item is established for a limited period of time from 2 to 3 years and then the costs are incorporated into the APC relative weights. By law, total pass-through payments are limited to a given percentage of total OPPS payments. In 2003, spending on pass-through items cannot exceed 2.5 percent of total outpatient PPS payments; in CY2004 and subsequently, the percentage is 2.0 percent. If CMS expects that pass-through payments will exceed this limit during a year, the agency is required to impose a uniform reduction in pass-through payments to meet that limit. CMS did not maintain the required budget neutrality from August 2000 to April 2002.

Current drugs and biologicals that have been in transitional pass-through status on or prior to January 1, 2000 were removed from that payment status effective January 1, 2003. CMS established separate APC payments for certain of these drugs, including selected orphan drugs, blood and blood products, and selected higher cost drugs in CY2003. CMS established a threshold of $150 per claim line for a drug to qualify for a separate APC payment as a higher-cost drug, other drugs that had qualified for a transitional pass-through payment were packaged into procedural APCs. For example, in some instances, brachytherapy seeds (radioactive isotopes used in cancer treatments) were packaged into payments for brachytherapy procedures. The payment rates for these APCs are based on a relative weight calculated in the same way as procedural APCs are calculated.

Generally, medical devices as well as drugs and biologicals are eligible for transitional pass-through payments when the cost of the device is not insignificant in relation to the OPPS payment amount; no existing or previously existing payment category is appropriate; and payment was not being made for the device as a HOPD services as of December 31, 1996. Under certain circumstances, the latter

requirement may not apply. The cost of a given drug, biological or device is considered not insignificant in relation to the amount payable for the applicable APC according to certain thresholds established by CMS. Medicare payment for devices is based on the amount that a hospital's charges, adjusted to costs, exceeds the portion of the OPPS payment associated with the device. Medicare payments for drugs and biologicals is based on the difference between 95 percent of their average wholesale price and the portion of the otherwise applicable APC payment rate attributable to the existing drug, subject to a budget neutrality provision. The pass-through amount for new drugs with a substitute drug recognized in a separate drug APC payment is the difference between 95 percent of new drug's AWP and the payment rate for the comparable dose of the associated drug's APC. Although transitional pass-through payments are subject to a budget neutrality requirement, the applicable budget neutrality requirement (2.5 percent through CY2003) was not effective until April, 2002. In 2002, after imposing the uniform reduction, CMS paid hospitals about 72 percent of AWP for transitional pass-through payments for these drugs and biologicals.

Outliers--Outlier payments are made for certain cases with high costs relative to the payment rate for the applicable APC group. In 2003, outliers are defined as services with estimated costs that exceed a threshold of 2.75 times its APC payment rate. Hospitals will be paid for 45 percent of the difference between the threshold and the estimated cost of the service. Aggregate outlier payments are limited to 2 percent of total OPPS payments and are financed by reducing the conversion factor by 2 percent.

Transitional corridor payments--A hospital may receive transitional corridor payments through 2003, the amount of which will depend upon the difference between a hospital's OPPS payments and what it would have received under the previous payment policy. Corridor payments will compensate a significant portion of a hospital's small loss and a smaller portion of a hospital's larger loss. These payments have diminished over the transition period. In 2003, corridor payments will compensate a hospital up to 60 percent of the difference that is less than 10 percent of what the hospital would have received under the previous policy, but only 6 percent of any difference that is greater than 10 percent.

AMBULATORY SURGICAL CENTER SERVICES

Services provided in an ambulatory surgical center (ASC) are paid under Medicare Part B. An ASC is a facility where surgeries that do not require an inpatient hospital admission are performed. ASCs treat only patients who have already seen a health care provider and for whom surgery has been selected as an appropriate treatment. All ASCs must have at least one dedicated operating room and the equipment needed to perform surgery safely and to provide for recovery from anesthesia. Patients electing to have surgery in an ASC arrive for a scheduled appointment on the day of the procedure, have the surgery in an operating room, and recover under the care of the nursing staff before leaving for home. According to MedPAC, the number of Medicare-certified ASCs more that doubled from

1,460 in 1991 to 3,371 in 2001. From 1997 through 2001, an average of over 270 new facilities began participating in Medicare a year, an increase that was partially offset by the average of 52 ASCs that closed or merged each year.

Medicare began covering ASC services in 1982 as a way to reduce costs for surgeries generally carried out on a hospital inpatient basis but that could be performed safely in a less costly outpatient setting. ASCs must meet certain conditions specified by Medicare in order to participate in the program. Some ASCs limit services to one type of surgery, such as ophthalmology, and others provide a variety of procedures, including gastroenterological, orthopedic, pain block, urology, podiatry, and ear, nose, and throat procedures. About half of all Medicare payments to ASCs in 2001 were related to cataract removal or lens insertion.

Payment for ambulatory surgical centers

From the start of Medicare coverage of ASC services, Medicare based its payments on a prospective payment fee schedule. This system was one of the first applications of a fee schedule for outpatient or ambulatory care. The two primary cost components of a surgical procedure are the physician's (or practitioner's) professional fees for performing the procedure and the costs associated with services furnished by the facility where the surgery is performed. Medicare pays ASCs for facility and nonphysician personnel costs incurred in connection with performing specific surgical procedures. As with other Medicare services, physician and certain practitioner fees are paid under the physician fee schedule.

Currently, over 2,400 procedures are included on the Medicare-approved list of ASC procedures. CMS determines which procedures will constitute the ASC list on the basis of certain criteria related to the safety, appropriateness, and effectiveness of performing the procedure in an ASC setting. CMS is required by law to update the list of procedures performed in ASCs that are eligible for Medicare pavement. The list of approved procedures was most recently updated in 2003. These Medicare-approved ASC procedures are consolidated into 9 payment groupings, each of which has one payment amount. The national payment rate for each of the groups equals the estimated median cost of procedures in the group. CMS adjusts the labor-related portion of the rate (currently 34.45 percent) using the hospital wage index for the ASC's location. Payments are also adjusted when multiple surgical procedures are performed at the same time. Generally, the ASC will receive full payment for the most expensive procedure and will receive 50 percent payment for the other procedures.

Medicare is required to update ASC rates every 5 years based on a survey of the actual audited costs incurred by a representative sample of ASCs for a representative sample of procedures. Between revisions, the rates are to be increased by the Consumer Price Index for All Urban Consumers (CPI-U). However, for fiscal years 1998-2002, BBA 1997 reduced the annual update to the CPI-U increase minus 2 percentage points. ASC's received an increase of approximately 2 percent for FY2003. The current projection of the CPI-U for FY2004 is 1.0145 percent.

For services on or after October 1, 2003, Medicare's base rates (prior to geographic adjustments) for ASC services are:

Group 1	$340	Group 6........	$690 + $150 for an intracular lens
Group 2	$455	Group 7........	1,015
Group 3	$520	Group 8........	839 + $150 for an intracular lens
Group 4	$643	Group 9........	1,366
Group 5	$731		

Proposed changes to ASC Medicare payments

On June 12, 1998, HCFA issued proposed rules which would make major changes in Medicare payments to ASCs. The major changes include replacing the payment groupings with an APC system comprised of 105 payment groups; updating underlying cost data using 1994 survey data updated to the present; and making additions to and deletions from the list of Medicare covered ASC procedures. Payments would range from $53 to $2,107 and would be updated by the CPI-U annually on a calendar year basis. BBRA 1999 did not address ASC payment rates, the proposed APC system, or update procedures. However, it requires that, if the Secretary implements new rates based on the 1994 data (or any rates based on pre-99 Medicare cost survey data), those new rates must be phased in by basing payments one-third on the new rates in the first year, two-thirds in the second year, and fully in the third year. BIPA prohibited implementation of a revised payment system for ASC facility services before January 1, 2002, extended the phase in of the APC system for ASCs to 4 years and required that by January 1, 2003, ASC rates be rebased using data from a 1999 or later Medicare survey. In its March 28, 2003 regulation, CMS stated that it has developed an ASC survey instrument, but believes that developing useful cost data will take at least 2 years. Moreover, CMS is studying its rate setting approach to ensure that its ASC payment system does not inadvertently worsen payment differentials across the various ambulatory sites of service that provide the same care.

AMBULANCE SERVICES

Covered Services

Medicare covers ambulance services only if they are furnished to a beneficiary whose condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

Nonemergency transportation is considered appropriate if: 1) the patient is bed confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or 2) if the medical condition is such that ambulance transportation is required. Special rules apply for nonemergency services. In the case of scheduled repetitive services, the ambulance provider or supplier must obtain an order from the beneficiary's attending physician; the order

must certify that the medical necessity requirements have been met. The following requirements apply for services that are unscheduled, or scheduled on a nonrepetitive basis:

- The ambulance provider or supplier must obtain, within 48 hours after transport, a written order from the beneficiary's attending physician if the beneficiary is a resident of a facility. No order is required for a beneficiary residing at home or not under the care of a physician.
- If the ambulance provider or supplier is unable to obtain the statement from the attending physician, then a statement must be obtained from a physician assistant, nurse practitioner, clinical nurse specialist, registered nurse or discharge planner. Such individual must have personal knowledge of the beneficiary's condition at the time the transport is ordered or the service is furnished. The individual must be employed by either the patient's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported.
- If the required certification is not obtained within 21 days, the supplier must document attempts to obtain such certification.

Medicare covers transportation from the point of origin to the nearest hospital, critical access hospital or skilled nursing facility that is capable of furnishing the required level and type of care for the beneficiary's illness or injury. The facility must have available the type of physician or physician specialist needed to treat the beneficiary's condition. The program also covers trips from such facilities to the beneficiary's home. In addition, the program covers trips from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident. Beneficiaries receiving renal dialysis treatments for ESRD can be transported to the nearest facility furnishing such services.

Payments for Services

Medicare pays for ambulance services on the basis of a fee schedule. The fee schedule, which went into effect April 1, 2002, is being phased-in over a five-year period. This fee schedule replaces the reasonable cost payment system that had applied for hospital providers of ambulance services and the reasonable charge payment system that had applied to other suppliers of ambulance services. (Critical access hospitals are exempt from the fee schedule and continue to be paid for ambulance services on the basis of reasonable costs.)

During a transition period (2002- 2006), payment under the program is based on a blend with a gradually increasing portion of the payment based on the fee schedule and a decreasing portion on the former payment methodology. In 2002, the payment equaled 20 percent of the fee schedule plus 80 percent of the previous reasonable cost or charge rates. In 2003, the blend is 40 percent of the fee schedule rates and 20 percent of cost or charge rates. In 2004, the blend will be 60 percent of the fee schedule, 40 percent of the cost or charge rates; in 2005 the blend will be 80 percent of the fee schedule and 20 percent of the cost or charge rates. In

2006, the payment will be based entirely on the fee schedule.

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); speciality care transport (SCT); and paramedic ALS intercept (PI). The air ambulance categories are: fixed wing air ambulance (FW) and rotary wing air ambulance (RW).

The fee schedule payment for an ambulance 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 to reflect the relative costs of providing services in various areas of the country. Additionally, the base rate is increased for air ambulance trips originating in rural areas and mileage payments are increased for all trips originating in rural areas.

The calculation for ground ambulance services is made as follows:

- The relative value assigned to the category of service is multiplied by the national dollar conversion factor. This is the unadjusted base rate.
- Seventy percent of the unadjusted base rate is multiplied by the geographic practice expense adjustment used for the physician fee schedule. This is added to thirty percent of the unadjusted base rate. The sum is the adjusted base rate.
- A mileage calculation is made. For urban areas, the regular mileage rate is multiplied by the number of miles. For rural areas, the regular mileage rate is increased by fifty percent for miles 1 - 17 and by 25 percent for miles 18 - 50; the regular mileage rate applies for all miles over 50. (No mileage rate applies for paramedic ALS intercept services).
- The adjusted base rate payment amount is added to the mileage payment. The sum is the fee schedule payment amount.

There are no relative values or conversion factor for air ambulance services. The fee schedule amount for these services is calculated as follows:

- Fifty percent of the published unadjusted base rate (for fixed or rotary wing, as appropriate) is multiplied by the geographic practice expense adjustment used for the physician fee schedule. This is added to fifty percent of the unadjusted base rate. The sum is the adjusted base rate payment.
- A mileage calculation is made by multiplying the mileage rate by the number of miles.
- The adjusted base rate payment amount is added to the mileage payment. The sum is the fee schedule payment amount.

For both ground and air ambulance services in 2003, 40 percent of the fee schedule payment amount is added to 60 percent of the payment calculated using the reasonable charge or cost method (whichever is appropriate) to give the actual payment amount.

The fee schedule amount is updated each year by the CPI-U. The update for 2003 is 1.1 percent.

HOME HEALTH SERVICES

Home health services are covered under both Medicare Part A and Medicare Part B. For a discussion of the benefit, see Part A discussion above.

PRESCRIPTION DRUGS

Coverage

Medicare beneficiaries who are inpatients of hospitals or skilled nursing facilities may receive drugs as part of their treatment. Medicare payments made to the facilities cover these costs. Medicare also makes payments to physicians for drugs or biologicals which cannot be self-administered. This means that coverage is generally limited to drugs or biologicals administered by injection. However, if the injection is generally self-administered (e.g., insulin), it is not covered.

In general, Medicare does not cover outpatient prescription drugs. However, despite the general limitation, the law specifically authorizes coverage for the following:

– *Immunosuppressive Drugs*-Drugs used in immunosuppressive therapy (such as cyclosporin) for individuals who have received a Medicare covered organ transplant.
– *Erythropoietin (EPO)*. EPO for the treatment of anemia for persons with chronic renal failure who are on dialysis.
– *Oral Anti-Cancer Drugs*. Drugs taken orally during cancer chemotherapy providing they have the same active ingredients and are used for the same indications as chemotherapy drugs which would be covered if they were not self-administered and were administered as incident to a physician's professional service. Also included are oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen.
– *Hemophilia clotting factors.* Hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors.
– Drugs that are necessary for the effective use of covered durable medical equipment, including those which must be put directly into the equipment (e.g., tumor chemotherapy agents used with an infusion pump).
– Injectable osteoporosis drug approved for treatment of post-menopausal osteoporosis provided by a home health agency to a homebound individual whose attending physician has certified suffers from a bone fracture related to post-menopausal osteoporosis and the individual is unable to self-administer the drug.

The program also covers the following immunizations:

– *Pneumococcal pneumonia vaccine*. The vaccine and its administration to a beneficiary if ordered by a physician.
– *Hepatitis B vaccine*. The vaccine and its administration to a beneficiary who is at high or intermediate risk of contracting hepatitis B.

– *Influenza virus vaccine*. The vaccine and its administration when furnished in compliance with any applicable State law. The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Payments

Payments for these drugs and immunizations are made under Medicare Part B. The payment for a drug equals 95 percent of the average wholesale price (AWP). On December 3, 2002, CMS sent a notice to contractors announcing the establishment of a single national price for each Medicare covered drug whose payment allowance is based on 95 percent of the AWP. Effective January 1, 2003, individual fiscal intermediaries and carriers no longer make the AWP determinations. Rather, they rely on the single drug pricer (SDP) files sent to them by CMS and process claims on the basis of the price shown on the applicable file. The new policy does not apply to drugs billed to DMERCs (durable medical equipment regional carriers) because DMERC-paid drug allowances are already consistent nationally. The policy also does not apply to hospital outpatient drugs (except blood clotting factors) because the payment allowance for such drugs is determined by a different procedure.

Medicare pays 80 percent of the recognized payment amount after the beneficiary has met the $100 Part B deductible. The beneficiary is liable for the remaining 20 percent coinsurance charges. These Part B cost-sharing charges do not apply for pneumococcal pneumonia or influenza vaccines.

OTHER PART B SERVICES

Preventive services

Screening mammograms--Medicare covers an annual screening mammography for all women over age 40. Payment for the mammogram is made under the physicians' fee schedule.

Screening Pap smears; pelvic exams--Medicare authorizes coverage for a screening Pap smear and a screening pelvic exam once every 2 years; annual coverage is authorized for women at high risk. Payment is based on the clinical diagnostic laboratory fee schedule (see above). A national minimum payment for Pap smears is established. In 2003, this is $14.76.

Prostate cancer screening tests--Medicare covers an annual prostate cancer screening test for men over age 50. The test can consist of any (or all) of the following procedures: (1) a digital rectal exam; (2) a prostate-specific antigen blood test; and (3) such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer.

Colorectal cancer screening--The law authorizes coverage of and establishes frequency limits for colorectal cancer screening tests. A covered test is any of the following procedures furnished for the purpose of early detection of colorectal cancer: (1) screening fecal-occult blood test (for persons over 50, no more than annually); (2) screening flexible sigmoidoscopy (for persons over 50, no

more than one every 4 years after a previous sigmoidoscopy or more than one every 10 years following a screening colonoscopy); (3) screening colonoscopy (no more than one every 2 years for high-risk individuals and no more than one every 10 years (or no more than 4 years after a screening flexible sigmoidoscopy) for other persons; and (4) such other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer. Barium enema tests, as an alternative to either a screening flexible sigmoidoscopy or a screening colonoscopy, are covered in accordance with the same screening parameters specified for those tests. Services are paid under the physician fee schedule (except that fecal occult blood tests are paid under the laboratory fee schedule). A facility payment may also apply if services are performed in an ambulatory surgical center or hospital outpatient department.

Diabetes Outpatient Self-Management Training--Medicare's covered benefits include diabetes outpatient self-management training services. These services are defined as including educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting. They are covered only if the physician or qualified non-physician practitioner who is managing the individual's diabetic condition certifies that the services are needed. Services must be provided under a comprehensive plan of care to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of their own condition. Certified providers for these purposes are defined as physicians or other individuals or entities that, in addition to providing diabetes outpatient self-management training services, provide other items or services reimbursed by Medicare. Providers must meet quality standards established by the Secretary. CMS currently accepts recognition of the American Diabetes Association (ADA) as meeting the National Standards for diabetes self-management training programs.

Medical Nutrition Therapy Services--Medicare authorizes coverage of medical nutrition therapy services (MNT) for certain beneficiaries who have diabetes or a renal disease. Services include nutritional, diagnostic, therapy and counseling services furnished by a registered dietician or nutrition professional, pursuant to a referral by a physician. Effective October 1, 2002, basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes is 3 hours. Basic coverage in subsequent years for renal disease or diabetes is 2 hours. The dietitian/nutritionist may choose how many units are performed per day as long as all of the other requirements are met. If the treating physician determines that receipt of both MNT and diabetes self-management training is medically necessary in the same episode of care, Medicare will cover both in the initial and subsequent years without decreasing either benefit as long as they are not provided on the same date of service. The dietitian/nutritionist may choose how many units are performed per day. In all cases, additional hours are considered to be medically necessary and covered if the treating physician determines that there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that

episode of care. Payment equals 85 percent of the amount established under the physician fee schedule for the service if it had been furnished by a physician.

Bone mass measurements--Bone mass measurement is covered for the following high risk persons: an estrogen-deficient woman at clinical risk for osteoporosis; an individual with vertebral abnormalities; an individual receiving long-term glucocorticoid steroid therapy; an individual with primary hyperparathyroidism; or an individual being monitored to assess osteoporosis drug therapy. Payments are made under the physician fee schedule. In general, the services are covered if they are provided no more frequently than once every 2 years.

Glaucoma Screening--The program provides for annual coverage for glaucoma screening for beneficiaries in the following high risk categories: (1) individuals with diabetes mellitus, (2) individuals with a family history of glaucoma, or (3) African-Americans age 50 and over. Medicare will pay for glaucoma screening examinations when they are furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist, who is legally authorized to perform the services under State law. Payments are made under the physician fee schedule.

Telehealth

Medicare pays for services which are furnished via a 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 to the physician or practitioner furnishing the service is equal to the amount that would be paid if the service had been furnished without the use of a telecommunications system. A facility fee is paid to the originating site (i.e. the site where the beneficiary is when the service is provided.) The fee equals the amount established for the preceding year, increased by the percentage increase in the Medicare economic index (MEI). The 2003 amount is $20.60.

Rural Health Clinics and Federally-Qualified Health Centers

Medicare covers services furnished by a qualified rural health clinic (RHC) located in an area which has a shortage of health personnel. The covered services RHCs may offer are divided into two basic groups-- rural health clinic services and other medical and other health services covered under Part B. Items and services which meet the definition of rural health clinic services are physicians' services; services and supplies incident to a physician's services; nurse practitioner and physician assistant services (including the services of specialized nurse practitioners and nurse midwives) that would be covered if furnished by a physician, provided the nurse practitioner or physician assistant is legally permitted to perform the services by the State in which they are performed; services and supplies incident to the services of nurse practitioners and physician assistants that would be covered if furnished incident to a physician's services; and visiting nurse services to the homebound. The program also covers services in Federally-qualified health centers (FQHCs). Covered services include those covered in RHCs

as well as preventive primary services.

Payments for RHC and FQHC services are based on an all inclusive rate for each beneficiary visit for covered services. An interim payment is made to the entity 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. Payment limits are updated on January 1 of each year by the Medicare economic index (MEI) which measures inflation for certain medical services. Because of the delay in implementing the MEI, there was one update on January 1, 2003 and a second one on March 1, 2003. For services provided January 1, 2003 - February 28, 2003, the RHC upper payment limit was $66.46, the urban FQHC limit was $103.18 and the rural FQHC limit was $88.71. For services provided March 1, 2003- December 31, 2003, the RHC upper payment limit is $66.72, the urban FQHC limit is $103.58, and the rural FHQC limit is $89.06. Assignment is mandatory; no deductible applies for FQHC services.

Comprehensive Outpatient Rehabilitation Facilities (CORFs)

A comprehensive outpatient rehabilitation facility (CORF) is a public or private institution that is engaged primarily in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services on an outpatient basis for the rehabilitation of injured, disabled or sick persons. The facility must provide at least the services of physicians (who are available to the facility on a full or part-time basis), physical therapy, and social or psychological services. Covered services also include occupational therapy, speech language pathology services, respiratory therapy, prosthetic and orthotic devices, nursing care, drugs which cannot be self-administered, supplies, and durable medical equipment. Payments for services are made under the physician fee schedule. Therapy services are subject to the therapy payment limitations (described above, for physical and occupational therapy providers). Mental health services are subject to the payment limitation for mental health services (described above).

Partial Hospitalization Services

Medicare covers partial hospitalization in connection with the treatment of mental illness. The services are covered only if the individual would otherwise require inpatient psychiatric care. The course of treatment must be prescribed, supervised, and reviewed by a physician. Services must be provided under a 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 by 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.

END-STAGE RENAL DISEASE SERVICES

COVERAGE

Medicare's End-Stage Renal Disease (ESRD) Program was established in the Social Security Amendments of 1972, and covers beneficiaries regardless of age. Eligible individuals have severe impairment of kidney function as a result of diabetes, hypertension, or other diseases that lead to ESRD. Prior to passage of the 1972 Amendments, treatment for ESRD was limited to a few individuals because of its high cost and the limited number of dialysis machines. ESRD is invariably fatal without treatment. Treatment takes two forms: transplantation and dialysis.

Beneficiaries must be: (1) fully insured for Old-Age and Survivors Insurance benefits; (2) entitled to monthly Social Security benefits; or (3) spouses or dependents of individuals described in (1) or (2). Such individuals must be medically determined to be suffering from ESRD and must file an application for benefits.

Benefits include all Part A and Part B medical items and services. ESRD beneficiaries are automatically enrolled in the Part B portion of Medicare and are required to pay the monthly Part B premium. Medicare coverage begins on the first day of the third month after the beneficiary begins a course of renal dialysis. In the case of a transplant candidate, coverage can begin as early as the month in which the patient is hospitalized for transplantation. No new waiting period is required when a beneficiary's entitlement has ended and the beneficiary needs to begin another course of dialysis or receive another kidney transplant. Medicare+Choice (M+C) plans may provide ESRD benefits to the Medicare beneficiary who is already enrolled in a M+C organization and subsequently develops ESRD. However, beneficiaries who have been recently diagnosed with ESRD cannot join a M+C plan.

Table 2-41 shows expenditures, number of beneficiaries, and the average expenditure per person for all persons with ESRD (including the aged and disabled) from 1974 through 2005. Total projected program expenditures for the Medicare ESRD Program for fiscal year 2003 are $15.0 billion; for fiscal year 2005, they are estimated to increase to $17.4 billion. In fiscal year 2003, there are an estimated 397,270 beneficiaries, including successful transplant patients and persons entitled to Medicare on the basis of age or disability who also have ESRD.

When the ESRD Program was created, it was assumed that program enrollment would level out at about 90,000 enrollees by 1995. That mark was passed several years ago, and no indication exists that enrollment will stabilize soon. Table 2-42 shows that new enrollment for all Medicare beneficiaries receiving ESRD services grew at an average annual rate of 6.8 percent from 1991 to 2000. Most of the growth in program participation is attributable to growth in the numbers of elderly people receiving services and growth in the numbers of more seriously ill people entering treatment. Table 2-42 shows the greatest rate of growth in program participation is in people over age 75, at 10.1 percent, followed by

people of ages 65-74 with a growth rate of 4.4 percent. The largest rate of growth in primary causes of people entering ESRD treatment was diabetes. People with diabetes frequently have multiple health problems, making treatment for renal failure more difficult.

TABLE 2-41--END-STAGE RENAL DISEASE MEDICARE BENEFICIARIES AND PROGRAM EXPENDITURES, SELECTED FISCAL YEARS 1974-2005

[Expenditures in millions of dollars]

Fiscal Year	Expenditures (HI & SMI)	HI Beneficiaries	Per Person Cost
1974	$229	15,993	$14,319
1975	361	22,674	15,921
1980	1,245	54,725	22,750
1985	2,835	96,965	29,237
1990	5,251	154,575	33,971
1991	5,634	170,718	33,002
1992	6,198	182,826	33,899
1993	6,947	201,168	34,532
1994	7,671	220,972	34,717
1995	8,567	239,057	35,838
1996	9,452	255,578	36,983
1997	10,467	282,062	37,109
1998	10,757	303,655	35,424
1999	10,549	323,238	32,635
2000	10,822	342,211	31,623
2001	12,622	358,753	35,184
2002	13,839	379,540	36,463
2003	15,033	397,270	37,841
2004	16,174	413,345	39,131
2005	17,373	428,383	40,556

Note-Estimates for 1982-2005 are subject to revision by the Office of the Actuary, Office of Medicare and Medicaid Cost Estimates; Estimates for 1998-2005 are under the Trustees 2003 assumptions.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

The rates of growth in older and sicker patients entering treatment for ESRD indicate a shift in physician practice patterns. In the past, most of these people would not have entered dialysis treatment because their age and severity of illness made successful treatment for renal failure less likely. Although the reasons that physicians have begun treating older and sicker patients are not precisely known, it is clear that these practice patterns have resulted, and will continue to result, in steady growth in the number of older patients receiving Medicare's ESRD services.

Outpatient Immunosuppressive Drug Coverage

Although the capability to perform transplants had existed since the 1950s, problems with rejection of transplanted organs limited its treatment for renal failure. The 1983 introduction of a powerful and effective immunosuppressive drug, cyclosporin, resulted in a dramatic increase in the number of transplants being performed and the success rate of transplantation. Medicare currently pays

80 percent of the cost for immunosuppressive drugs required after a covered Medicare transplantation.

TABLE 2-42--INCIDENT COUNTS OF REPORTED ESRD: ALL PATIENTS, BY DEMOGRAPHIC CHARACTERISTICS AND PRIMARY DIAGNOSIS, SELECTED YEARS 1991-2000

Characteristic or Primary Diagnosis	1991	1993	1995	1996	1997	1998	1999	2000
0-4	131	120	124	128	108	98	93	129
5-9	108	97	102	94	79	84	93	80
10--14	211	194	211	208	186	181	175	174
15-19	402	425	453	424	347	372	385	351
20-24	818	827	824	810	720	744	668	664
25-29	1,430	1,443	1,331	1,295	1,248	1,254	1,202	1,211
30-34	1,994	2,050	2,035	1,897	1,763	1,817	1,767	1,714
35-39	2,425	2,545	2,709	2,629	2,489	2,458	2,559	2,375
40-44	3,002	3,083	3,419	3,420	3,265	3,466	3,368	3,380
45-49	3,146	3,657	4,189	4,276	4,161	4,524	4,613	4,599
50-54	3,486	4,086	4,771	4,751	5,100	5,455	5,840	5,905
55-59	4,475	4,912	5,580	5,642	5,999	6,486	6,783	6,836
60-64	5,962	6,364	7,120	7,121	7,314	7,735	7,813	7,991
65-69	7,895	8,765	9,351	9,902	10,353	10,658	10,660	10,683
70-74	7,215	8,432	9,464	10,332	10,871	11,342	11,547	11,623
75-79	5,337	6,228	7,255	8,182	9,077	9,862	10,761	10,983
80-84	2,734	3,386	4,184	4,813	5,591	5,979	6,566	7,036
85+	1,100	1,465	2,182	2,182	2,524	3,059	3,461	3,700
Unknown	-	-	-	-	-	-	-	10
0-19	852	836	890	854	720	735	746	734
20-44	9,669	9,948	10,318	10,051	9,485	9,739	9,564	9,344
45-64	17,069	19,019	21,660	21,790	22,574	24,200	25,049	25,331
65-74	15,110	17,197	18,815	20,234	21,224	22,000	22,207	22,306
75+	9,171	11,079	13,233	15,177	17,192	18,900	20,788	21,719
Unknown	-	-	-	-	-	-	-	10
Male	27,852	31,130	34,515	36,721	38,135	40,469	42,274	42,826
Female	24,024	26,951	30,401	31,379	33,060	35,107	36,081	36,615
White	34,073	37,217	41,165	42,952	46,454	48,794	51,549	52,622
Black	15,706	18,201	19,559	20,503	20,661	22,164	22,260	22,040
Native American	700	787	1,043	1,150	821	1,231	920	953
Asian	1,290	1,683	2,090	2,260	2,121	2,459	2,611	2,510
Other/unknown	107	193	1,062	1,242	1,140	934	1,019	1,319
Hispanic	1,610	2,548	6,101	7,499	7,435	8,239	8,350	8,482
Non- Hispanic	50,266	55,533	58,818	60,608	63,762	67,343	70,009	70,962
Diabetes	18,746	20,594	26,324	29,219	31,273	33,615	34,852	35,310
Hypertension	15,498	16,465	16,862	17,948	19,264	20,503	21,260	21,038
Glomerulone-phritis	6,103	6,185	6,765	7,113	6,883	6,951	6,770	6,187
Cystic kidney	1,491	1,519	1,691	1,590	1,620	1,701	1,738	1,604
Other urologic	1,101	999	1,185	1,385	1,296	1,336	1,412	1,339
Other cause	4,859	5,048	6,731	7,061	7,319	7,686	7,902	7,972
Unknown cause	2,242	2,167	2,257	2,553	2,694	2,947	2,935	3,081
Missing disease	1,836	5,104	3,104	1,238	848	843	1,490	2,913

TABLE 2-42--INCIDENT COUNTS OF REPORTED ESRD: ALL PATIENTS, BY DEMOGRAPHIC CHARACTERISTICS AND PRIMARY DIAGNOSIS, SELECTED YEARS 1991-2000

Characteristic or Primary Diagnosis	1991	1993	1995	1996	1997	1998	1999	2000
U.S.	51,162	57,294	64,014	67,140	70,212	74,516	77,250	78,363
U.S. territories	56	59	80	95	107	121	113	123
Puerto Rico	609	667	791	855	861	915	969	931
Foreign	13	10	11	13	12	21	13	19
Unknown	36	51	13	-	-	-	14	-
All	51,876	58,081	64,919	68,107	71,197	75,582	78,359	79,444

Note-The incident cohorts and associated modalities are determined at the time of ERSD initiation without applying the 60-day stable modality rule. The age of the incident patient is determined as of the date of ERSD initiation. CMS has only started collecting Hispanic ethnicity data as of April 1995, so Hispanic data in years prior to 1995 has been left blank.

[1]Values for cells with fewer than 10 patients are suppressed.

Source: www.usrds.org/2002/Medicare_only/A_Medicare_only.pfd.

Immunosuppressive drug coverage under Medicare began with The Omnibus Budget Reconciliation Act of 1986 (OBRA '86), which provided coverage up to 1 year from the date of discharge from a Medicare-covered transplant. Subsequent legislation extended the coverage. The Beneficiary Improvement and Protection Act (BIPA) (P.L. 106-554), provided lifetime coverage for immunosuppressive drugs to Medicare aged and disabled beneficiaries following a transplant covered by Medicare, effective December 21, 2000. However, persons who are under age 65 and entitled to Medicare based solely on their diagnosis of ESRD will lose their ESRD Medicare entitlement 3 years after transplantation, and, effectively, lose coverage for the necessary immunosuppressive drugs. They will be eligible again when they reach age 65.

TREATMENT

Table 2-43 indicates that a total of 14,628 kidney transplants were performed in Medicare-certified U.S. hospitals in 2001. Kidneys are the most frequently transplanted organ and Medicare covers nearly 90 percent of all kidney transplant beneficiaries in the U.S. Medicare appears to be the primary payer in approximately 50 percent of all kidney transplants in the U.S. and is at least the secondary payer in nearly 60 percent of all kidney transplants. Despite the significant increases in the number and success of kidney transplants, transplantation is not the treatment of choice for all ESRD patients. A chronic, severe shortage of kidneys available for transplantation limits the number of patients who can receive transplants. Even absent a shortage of organs, some patients are not suitable candidates for transplants because of their age, severity of illness, or other complicating conditions. Finally, some ESRD patients do not want an organ transplant.

For all of these reasons, dialysis is likely to remain the primary treatment for ESRD. Medicare pays for 75-80 percent of all dialysis care. Dialysis is an artificial method of performing the kidney's function of filtering blood to remove waste products and toxins. There are two types of dialysis: hemodialysis and peritoneal dialysis. The method chosen by the majority of Medicare beneficiaries is hemodialysis, which requires blood to be removed from the body, filtered and cleansed through a dialyzer–sometimes called an artificial kidney machine--before being returned to the body. Hemodialysis is usually performed three times a week in a clinic or hospital, and takes three to four hours, depending on the patient.

TABLE 2-43--TOTAL KIDNEY TRANSPLANTS PERFORMED IN MEDICARE-CERTIFIED U.S. HOSPITALS, 1999-2001

Calendar Year	Total Transplants	Living Donor		Cadaveric Donor	
		Number	Percent	Number	Percent
1999	13,483	4,644	34	8,839	66
2000	14,311	5,427	38	8,884	62
2001	14,628	5,804	40	8,824	60

Source: Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality.

Peritoneal dialysis filtering takes place inside the body by inserting dialysate fluid through a permanent surgical opening in the peritoneum (abdominal cavity). Toxins filter into the dialysate fluid and are then drained from the body through the surgical opening. There are three types of peritoneal dialysis: intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD)-- both of which require the use of a machine and the assistance of a partner--and continuous ambulatory peritoneal dialysis (CAPD)-- which does not require a machine.

IPD can be done at home but is usually done in a hospital--treatments are performed several times a week, for a total of 36 to 42 hours per week. The CAPD and CCPD require daily exchanges of dialysate fluid and both can be performed at home. CAPD can be done at any time and is the most popular form of peritoneal dialysis. The process involves draining the dialysate and replacing fresh solution which takes 30 to 40 minutes and the solution is usually changed four times a day. CCPD is usually done at night while the individual is asleep, requiring 10 to 12 hours per night.

REIMBURSEMENT

Medicare reimbursement for dialysis services provided by hospital-based and independent facilities are paid at prospectively determined rates–the necessary dialysis-related services, equipment, and supplies are furnished for a predetermined fixed fee per dialysis treatment. The rate, referred to as a composite rate, is derived from a base rate and adjusted by local area wage differences and audited cost data adjusted for the national proportion of patients dialyzing at home versus in a facility. Adjustments are made to the composite rate for hospital-based dialysis

facilities to reflect higher overhead costs. Some examples of services included under the composite rate are: cardiac monitoring, catheter changes, dressing changes, suture removal, all oxygen and its administration, and declotting of shunt. If a facility fails to furnish any part of the items and services covered under the rate, then the facility cannot be paid any amount for the part of the items and services that it did furnish.

Beneficiaries electing home dialysis may choose either to receive dialysis equipment, supplies, and support services directly from the facility with which the beneficiary is associated (method I) or to make independent arrangements for equipment, supplies, and support services (method II). Under method I, the equipment, supplies, and support services are included in the facility's composite rate. Under method II, payments are made on the basis of reasonable charges and limited to 100 percent of the median hospital composite rate, except for patients on CCPD, in which case the limit is 130 percent of the median hospital composite rate. Neither the composite rate nor the reasonable charge payment for method II is routinely updated.

The composite rate for renal dialysis was updated in the BBRA. The act increased the composite rate for 2000 by 1.2 percent above the revised composite rate that was in effect in 1999. An additional 1.2 percent was authorized for 2001 . BIPA modified the BBRA provision to provide for a 2.4 percent increase to the composite rate beginning in 2001. The maximum composite rate cap (maximum allowed payment per treatment) as of January 2002 is $144.59 per treatment for urban centers and $144.05 for rural areas.

Kidney transplantation services are inpatient hospital services and they are subject to the Medicare prospective payment system (PPS). The costs of care for actual and potential kidney donors are fully covered by Medicare and include all reasonable preparatory, operation, and post-operation recovery expenses associated with donation, without regard to deductibles, coinsurance, and premium payments. Post-operation recovery expenses are limited to the actual period of recovery, however. There is also no specific update policy for reasonable costs of kidney acquisition, and 100 percent of reasonable costs is reimbursed.

MEDICARE+CHOICE

Medicare has a long-standing history of offering its beneficiaries an alternative to the traditional fee-for-service program. Health Maintenance Organizations and other types of managed care plans have been allowed to participate in the Medicare program, beginning with private health plan’s contracts in the 1970s and the Medicare risk contract program in the 1980s. Then, in 1997, Congress passed the Balanced Budget Act of 1997 (BBA, P.L. 105-33), replacing the risk contract program with the Medicare+Choice (M+C) program. The M+C program established new rules for beneficiary and plan participation, along with a new payment methodology. In addition to controlling costs, the M+C program was also designed to expand private health plans to markets where access to managed care plans was limited or nonexistent and to offer new types of private health plans.

The 106th Congress enacted legislation to address some issues arising from the BBA changes. The Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) changed the M+C program in an effort make it easier for Medicare beneficiaries and plans to participate in the program. Further refinements to the M+C program were included in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554). The 107th Congress passed The Public Health Security and Bioterrorism Preparedness and Response Act (P.L. 107-188) which included a few temporary changes to deadlines in the Medicare+Choice program.

In 2003, Medicare+Choice plans were available to about 59 percent of the over 40 million Medicare beneficiaries, and in March 2003 about 12 percent of them chose to enroll in one of the 146 (including two private-fee-for service plans) available Medicare+Choice plans. The rapid growth rate of Medicare managed care enrollment in the 1990s leveled off with the implementation of the M+C program, and in fact, there has been a continuous decline in enrollment since 1999 when 17 percent of beneficiaries were enrolled in M+C plans.

In order to increase enrollment in Medicare managed care and to allow beneficiaries to better meet their health care needs, the M+C program offers a diverse assortment of managed care plans. However, achieving the goals of the M+C program has been difficult, in part because the goal to control Medicare spending which led to a slowdown in the rate of increase in payments to plans, may have dampened interest by managed care entities in developing new markets, adding plan options, and maintaining their current markets (see Appendix E for further information about the M+C program).

SELECTED ISSUES

SECONDARY PAYER

Generally, Medicare is the ``primary payer,'' that is, it pays health claims first, with an individual's private or other public health insurance filling in some or all of Medicare's coverage gaps. However, in certain cases, the individual's other coverage pays first, while Medicare is the secondary payer. This phenomenon is referred to as the Medicare Secondary Payer Program.

An employer (with 20 or more employees) is required to offer workers age 65 and older (and workers' spouses age 65 and older) the same group health insurance coverage as is made available to other employees. Workers have the option of accepting or rejecting the employer's coverage. If the worker accepts the coverage, the employer's plan is primary for the worker and/or spouse who is over age 65; Medicare becomes the secondary payer. Employers may not offer a plan that circumvents this provision.

Similarly, a group health plan, offered by a large employer with 100 or more employees, is the primary payer for employees or their dependents who are on the Medicare disability program. The provision applies only to persons covered under the group health plan because the employee (generally the spouse of the disabled

person) is in "current employment status" (i.e., is an employee or is treated as an employee by the employer). Secondary payer provisions also apply to ESRD individuals with employer group health plans (regardless of employer size). The group health plan is the primary payer for 30 months for persons who become eligible for Medicare ESRD benefits.

Medicare is also the secondary payer when payment has been made, or can reasonably be expected to be made, under workers' compensation, automobile medical liability, all forms of no-fault insurance, and all forms of liability insurance.

The law authorizes a data match program which is intended to identify potential secondary payer situations. Medicare beneficiaries are matched against data contained in Social Security Administration and Internal Revenue Service files to identify cases in which a working beneficiary (or working spouse) may have employer-based health insurance coverage. Cases of previous incorrect Medicare payments are identified and recoveries are attempted. Recoveries can be initiated up to 3 years after the date the service was furnished. Further, recoveries may be made from third-party administrators except where such administrators cannot recover amounts from the employer or group health plan.

Table 2-44 shows savings attributable to these Medicare secondary payer provisions. In fiscal year 2002, combined Medicare Part A and B savings are estimated at $4.3 billion.

TABLE 2-44--MEDICARE SAVINGS ATTRIBUTABLE TO SECONDARY PAYER PROVISIONS, FISCAL YEARS 1996-2002

[In Millions of Dollars]

Year and Medicare Part	Workers' Compensation	Working Aged	End-Stage Renal Disease	Automobile	Disability	Total
1996:						
Part A	93.6	1,062.5	133.4	335.0	728.5	2,353.0
Part B	11.1	295.1	34.3	50.1	196.4	586.9
Total	104.7	1,357.6	167.6	385.0	924.9	2,939.9
1997:						
Part A	99.7	1,046.5	114.3	366.8	697.5	2,324.9
Part B	11.8	276.4	32.4	63.7	178.9	563.2
Total	111.5	1,322.9	146.7	430.5	876.3	2,888.1
1998:						
Part A	96.7	1,303.0	108.1	219.2	810.8	2,683.9
Part B	11.6	364.3	35.0	28.0	238.4	707.7
Total	108.3	1,667.3	143.1	247.2	1,049.2	3,391.6
1999:						
Part A	85.3	1,300.0	120.3	211.4	873.9	2,763.6
Part B	11.9	400.0	42.6	29.6	282.6	791.0
Total	97.2	1,700.0	162.9	241.0	1,156.5	3,554.6
2000:						
Part A	89.9	1,026.0	122.6	209.1	772.6	2,419.4
Part B	13.3	327.3	44.1	32.2	254.0	701.0
Total	103.2	1,353.3	166.7	241.3	1,026.6	3,120.4

TABLE 2-44--MEDICARE SAVINGS ATTRIBUTABLE TO SECONDARY PAYER PROVISIONS, FISCAL YEARS 1996-2002-continued

[In Millions of Dollars]

Year and Medicare Part	Workers' Compensation	Working Aged	End-Stage Renal Disease	Automobile	Disability	Total
2001:						
Part A	81.4	1,212.0	129.0	202.7	947.8	2,761.8
Part B	14.6	414.2	43.1	48.9	330.4	882.6
Total	96.0	1,626.2	172.1	251.6	1,278.2	3,644.4
2002:						
Part A	89.7	1,482.9	151.4	263.5	1,139.5	3,318.0
Part B	16.5	459.8	48.1	33.0	369.0	960.5
Total	106.2	1,942.7	199.5	296.5	1,508.5	4,278.5

Note-Liability savings are included in the total.

Source: Centers for Medicare & Medicaid Services, Office of Financial Management.

SUPPLEMENTING MEDICARE COVERAGE

Most beneficiaries depend on some form of private or public coverage to supplement their Medicare coverage. In 2000, only about 13 percent of beneficiaries relied solely on the traditional fee-for-service Medicare program for protection against the costs of care; an additional 13 percent were enrolled in managed care organizations. See Appendix B for a discussion of supplementary coverage and Appendix E for a discussion of Medicare+Choice.

LEGISLATIVE HISTORY, 1997-2003

This section summarizes major Medicare legislation enacted into law, beginning in 1997. Previous editions of the Green Book review legislation enacted prior to that date. The summary highlights major provisions; it is not a comprehensive list of all Medicare amendments. Included are provisions which had a significant budget impact, changed program benefits, modified beneficiary cost sharing, or involved major program reforms. Provisions involving policy changes are mentioned the first time they are incorporated in legislation, but not necessarily every time a modification is made. The descriptions include either the initial effective date of the provision or, in the case of budget savings provisions, the fiscal years for which cuts were specified.

BALANCED BUDGET ACT (BBA) OF 1997 (P.L. 105-33)

Hospitals

Froze PPS hospital and PPS-exempt hospitals and units and limited updates for fiscal years 1999-2002. Established a PPS for inpatient rehabilitation hospitals, effective beginning in fiscal year 2001. Rebased capital payment rates and provided for additional reductions over the fiscal year 1997-2002 period. Reduced the indirect medical education payment from 7.7 percent to 5.5 percent by fiscal year

2001 and reformed direct graduate medical education payments (generally effective on enactment or October 1, 1997).

Skilled nursing facilities

Provided for a phase in of a PPS that will pay a Federal per-diem rate for covered SNF services (generally effective July 1, 1998).

Home health

Provided for the establishment of a PPS for home health services. Provided for a reduction in per-visit cost limits prior to the implementation of the PPS, clarified the definitions of part-time and intermittent care, and provided for a study of the definition of homebound. Provided for the transfer of some home health costs from Part A to Part B (prospective payment effective October 1, 1999, reduction in cost limits effective on enactment, definition clarification effective October 1, 1997, and transfer of costs effective January 1, 1998).

Hospice

Reduced the hospice payment update for each of fiscal years 1998-2002, and clarified the definition of hospice care (generally effective on enactment).

Physicians

Provided for use of a single conversion factor; replaced the volume performance standard with the sustainable growth rate; provided for phased-in implementation of resource-based practice expenses; and permitted use of private contracts under specified conditions (generally effective January 1, 1998).

Hospital outpatient departments

Extended reductions in payments for outpatient hospital services paid on the basis of costs through December 1999 and established a PPS for hospital outpatient departments (OPDs) for covered services beginning in 1999 (generally effective on enactment).

Other providers

Froze payments for laboratory services for fiscal years 1998-2002; provided for establishment of a fee schedule in 2000 for payment for ambulance services (generally effective on enactment).

Beneficiary payments

Permanently set the Part B premium at 25 percent of program costs and expanded the premium assistance beginning in 1998 available under the Specified Low-Income Medicare Beneficiary (SLMB) Program (effective on enactment).

Prevention initiatives

Authorized coverage for annual mammograms for all women over 40. Added coverage for screening pelvic exams, prostate cancer screening tests,

colorectal cancer screening tests, diabetes self-management training services, and bone mass measurements for certain high-risk persons (generally effective in 1998, except prostate cancer screening effective 2000).

Supplementary coverage
Provided for guaranteed issuance of specified Medigap policies without a preexisting condition exclusion for certain continuously enrolled aged individuals (effective July 1, 1998).

Competitive bidding
Provided for competitive bidding demonstrations for furnishing Part B services (not including physicians services) (effective on enactment).

Commissions
Established a 17-member National Advisory Commission on the Future of Medicare (with appointments to be made by December 1, 1997). Established the Medicare Payment Advisory Commission replacing the Prospective Payment Assessment Commission and the Physician Payment Review Commission (with appointments to be made by September 30, 1997).

Medicare+Choice
Established a new part C of Medicare called Medicare+Choice (M+C). Built on the existing Medicare Risk Contract Program which enabled beneficiaries to enroll, where available, in health maintenance organizations (HMOs) that contracted with the Medicare Program. Expanded, beginning in 1999, the private plan options that could contract with Medicare to other types of managed care organizations (for example, preferred provider organizations and provider-sponsored organizations), private fee-for-service plans, and, on a limited demonstration basis, high deductible plans (called medical savings account plans) offered in conjunction with medical savings accounts (effective on enactment).

BALANCED BUDGET REFINEMENT ACT (BBRA) OF 1999 (INCORPORATED IN CONSOLIDATED APPROPRIATIONS ACT OF 1999, P.L.106-113)

Prospective payment system hospitals
Froze the indirect medical education adjustment at 6.5 percent through fiscal year 2000, reduced the adjustment to 6.25 percent in fiscal year 2001 and to 5.5 percent in fiscal year 2002 and subsequent years. Froze the reduction in the DSH adjustment to 3 percent in fiscal year 2001; changed the reduction to 4 percent in fiscal year 2002. Changed the methodology for Medicare's direct graduate medical education payments to teaching hospitals to incorporate a national average amount calculated using fiscal year 1997 hospital- specific per-resident amounts. Increased the number of years that would count as an initial period for child neurology residency training programs. Provided for the reclassification of certain counties

and areas for the purposes of Medicare reimbursement.

PPS-exempt hospitals

Adjusted the labor-related portion of the 75-percent cap to reflect the wage differences in the hospitals' area relative to the national average. Increased the amount of continuous bonus payments to eligible long-term care and psychiatric providers from 1 percent to 1.5 percent for cost reporting periods beginning on or after October 1, 2000 and before September 30, 2001 and to 2 percent for cost reporting periods beginning on or after October 1, 2001 and before September 30, 2002. Required the Secretary to report on a discharge-based PPS for long-term care hospitals which would be implemented in a budget neutral fashion for cost reporting periods beginning on or after October 1, 2002. Required the Secretary to report on a per-diem-based PPS for psychiatric hospitals which would be implemented in a budget neutral fashion for cost reporting periods beginning on or after October 1, 2002. Required the Secretary to base the PPS for inpatient rehabilitation hospitals on discharges and incorporate functional related groups as the basis for payment adjustments.

Rural providers

Permitted reclassification of certain urban hospitals as rural hospitals. Updated existing criteria used to designate outlying rural counties as part of metropolitan statistical areas for the purposes of Medicare’s hospital IPPS. Changed certain requirements pertaining to Medicare's Critical Access Hospital Program. Extended the Medicare dependent hospital classification through fiscal year 2006. Permitted certain sole community hospitals to receive Medicare payments based on their hospital specific fiscal year 1996 costs. Increased the target amount for SCHs by the full market basket amount for discharges occurring in fiscal year 2001.

Skilled nursing facilities

Increased per-diem payments by 20 percent for 15 resource utilization groups (RUGs) under the PPS from April 1, 2000, until such time as the Secretary of HHS implements refinements to the RUGs. SNFs were permitted to elect to be paid under the full Federal PPS rate for SNFs (rather than go through the transitions period). Provided a temporary 4 percent increase in the Federal per-diem rate for SNF services for FY 2001 and FY 2002. The increase could not be considered in the base amount used to compute subsequent updates to the Federal per-diem rate. Expanded the list of services excluded from SNF PPS to include certain chemotherapy items and administration services, certain radioisotope services, certain prosthetic devices, and ambulance services furnished in conjunction with renal dialysis treatments, beginning in FY 2001. Any increase in total payments resulting from these exclusions are required to be budget neutral. Allowed SNFs with a 60 percent immunocompromised patient population to be paid temporarily a 50/50 blend of their facility-specific and Federal rates beginning with the first cost reporting period beginning after enactment of BBRA and ending on September 30,

2001. Required reports on the resource use of AIDS patients (by the Secretary), on SNF costs in Alaska and Hawaii (by MedPAC), and on respiratory therapy State licensure, certification standards, and competency examinations (by the Secretary).

Home health agencies

Delayed the 15-percent reduction in home health payments until 12 months after implementation of the PPS and, within 6 months of implementation, required the Secretary to assess the need for any reductions. Increased per-beneficiary limits by 2 percent for agencies whose per-beneficiary limit was below the national median; excluded DME from consolidated billing, and provided agencies an additional $10 per beneficiary to offset costs for collecting outcome and assessment information set (OASIS) data.

Hospice

Increased payment rates otherwise in effect under the hospice PPS for fiscal year 2001 by 0.5 percent and for fiscal year 2002 by 0.75 percent, provided that these increases are not to be included in the base on which subsequent increases will be computed.

Physicians

Made technical changes to limit oscillations in the annual update to the conversion factor beginning in 2001 and provided that the sustainable growth rate is calculated on a calendar year basis. Required the Secretary, in determining practice expense relative values, to establish by regulation a process under which the Secretary would accept for use and would use, to the maximum extent practicable and consistent with sound data practices, data collected by outside organizations and entities.

Hospital outpatient departments

Made seven major changes to Medicare payments under the HOPD OPPS: (1) required the Secretary of the U.S. Department of Health and Human Services (DHHS) to provide payments (within specified limits, and on a budget neutral basis) over and above PPS payments for certain high cost ("outlier") patients; (2) as a transition to the PPS, for 2-3 years, on a budget neutral basis, required the Secretary of DHHS to provide ``passthrough payments" to hospital OPDs above and beyond PPS payments for costs of certain ``current innovative" and ``new, high cost" devices, drugs, and biologicals; (3) limited the cost range of items or services that are included in any one PPS category and required the Secretary to review the PPS groups and amounts annually and to update them as necessary; (4) as a transition to the PPS, through 2003, limited the reduction in Medicare payments individual hospitals experience due to the PPS; (5) provided special payments until 2004 for small, rural hospitals to ensure that they receive no less under the outpatient PPS than they would have received under the prior system and provided the same protection permanently for cancer hospitals; (6) limited beneficiary copayments for outpatient care to no more than the amount of the beneficiary

deductible for inpatient care; and (7) required that the pre-PPS payment base used as the budget neutrality benchmark for the PPS include beneficiary coinsurance amounts as paid under the pre-PPS system (i.e., 20 percent of hospital charges).

Therapy services

Suspended for 2 years (2001 and 2002) application of the caps on physical therapy and occupational therapy services.

Pap smears

Set the minimum payment for the test component of a Pap smear at $14.60.

Immunosuppressive drugs

Extended the 36-month limit on coverage of immunosuppressive drugs for persons exhausting their coverage in 2000-2004. Set the increase for persons exhausting benefits in 2000 at 8 months, and limited total expenditures to $150 million over the 5 years.

Studies

Required a number of studies including a Medicare Payment Advisory Commission comprehensive study of the regulatory burdens placed on all classes of providers under fee-for- service Medicare and the associated costs. Required GAO to conduct a study of Medigap policies.

Medicare+Choice

Contained several provisions designed to facilitate the implementation of M+C. Changed the phase in of the new risk adjustment payment methodology based on health status to a blend of 10 percent new health status method/90 percent old demographic method in 2000 and 2001, and not more than 20 percent health status in 2002. Provided for payment of a new entry bonus of 5 percent of the monthly M+C payment rate in the first 12 months and 3 percent in the subsequent 12 months to organizations that offer a plan in a payment area without an M+C plan since 1997, or in an area where all organizations announced withdrawal as of January 1, 2000. Reduced the exclusion period from 5 years to 2 years for organizations seeking to reenter the M+C Program after withdrawing. Allowed organizations to vary premiums, benefits, and cost sharing across individuals enrolled in the plan so long as these are uniform within segments comprising one or more M+C payment areas. Provided for submission of adjusted community rates by July 1 instead of May 1. Provided that the aggregate amount of user fees collected would be based on the number of M+C beneficiaries in plans compared to the total number of beneficiaries. Delayed implementation of the Medicare+Choice Competitive Bidding Demonstration Project.

IPPS hospitals

Provided the full market basket update to all hospitals for FY2001. Established that all hospitals are eligible to receive DSH payments when their DSH percentage (threshold amount) exceeds 15 percent. Decreased the scheduled reduction in IPPS hospitals' DSH payments. Established that the cost of new medical technologies should be recognized with a budget neutral payment adjustment in IPPS by October 1, 2001. Established that starting for FY2001 Medicare Geographic Classification Review Board (MGCRB) decisions, the reclassification of an IPPS hospital for use of a different area's wage index is effective for 3 fiscal years. Modified teaching hospitals' indirect medical education (IME) percentage adjustment. Established that a teaching hospital's approved per resident amount for cost reporting periods beginning during FY2002 is not less than 85 percent of the locality adjusted national average per resident amount. Changed a hospital's payment of the direct costs of approved nursing and allied health payments to incorporate Medicare managed care enrollees. Permitted certain independent laboratories to continue to bill Medicare directly for the technical component of pathology services provided to hospital inpatients and hospital outpatients under a grandfather arrangement for a 2-year period (2001-2002).

IPPS exempt hospitals

Established that total payments for inpatient rehabilitation facility (IRF) services in FY2002 would equal the amounts of payments that would have been made if the IRF prospective payment system (PPS) had not been enacted. Permitted an IRF to make a one-time election during the transition period to be paid based on a fully phased-in IRF-PPS rate. Increased the incentive payments for psychiatric hospitals and distinct part units to 3 percent for cost reporting periods beginning on or after October 1, 2000. Increased the national cap for long-term care hospitals by 2 percent and the target amount by 25 percent for cost reporting periods beginning during FY2001. Required the Secretary to examine the feasibility and impact of basing payment on the existing (or refined) acute hospital DRGs and using the most recently available hospital discharge data when developing the PPS for long-term care hospitals.

Rural providers

Modified the critical access hospital (CAH) program: (1) eliminated liability of Medicare beneficiaries for coinsurance, deductible, copayment, or other cost sharing amount with respect to clinical diagnostic laboratory services furnished as an outpatient CAH service; (2) permitted CAHs to elect outpatient payments based on reasonable costs plus an amount based on 115 percent of Medicare's fee schedule for professional services; (3) exempted swing beds in CAHs from the

SNF prospective payment system; (4) provided for payment to CAHs for the compensation and related costs for on-call emergency room physicians who are not present on the premises, are not otherwise furnishing services, and are not on-call at any other provider or facility; and (5) specified that ambulance services provided by a CAH (or provided by an entity that is owned or operated by a CAH) are paid on a reasonable cost basis if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of the CAH.

Modified the Medicare dependent hospital (MDH) classification so that an otherwise qualifying small rural hospital may be classified as an MDH if at least 60 percent of its days or discharges were attributable to Medicare Part A beneficiaries in at least two of the three most recent audited cost reporting periods. Permitted sole community hospitals to elect payment based on hospital specific, updated FY1996 costs if this target amount resulted in higher Medicare payments. Increased payments to providers of ground ambulance services for trips originating in rural areas that are greater than 17 miles and up to 50 miles. Provided permanent authority to physician assistants who owned rural health clinics which lost their designation as such to bill Medicare directly. Revised Medicare reimbursement for telehealth services. Exempted rural health clinics operated by hospitals with less than 50 beds from the per-visit payment method.

Skilled Nursing Facilities

Provided higher payments to SNFs by increasing the update to the full market basket for FY 2001 and the market basket minus 0.5 percentage point for FY 2002 and FY 2003. The nursing component of the Federal rate was temporarily increased by 16.66 percent beginning April 1, 2000 through October 1, 2002. BIPA also corrected a payment anomaly created by BBRA by temporarily increasing all the rehabilitation RUGs by 6.7 percent (rather than the 20 percent for 3 specific rehabilitation RUGs). This adjustment also remains in effect until the Secretary implements case mix refinements. BIPA also limited application of the consolidated billing requirement to Part A-covered stays and to therapy services furnished during Part A and Part B-covered stays. Permited the Secretary to establish a procedure for geographic reclassification for SNFs under PPS. The provision required the Secretary to collect the data necessary to establish a wage index for SNFs prior to establishing a geographic reclassification process. Required reports on different systems for categorizing patients in SNFs in a manner that accounts for the relative resource utilization of different patient types (by the Secretary); on the adequacy of Medicare payments to SNFs (by the GAO); and on nurse staffing ratios and the impact of the 16.66 percent increase in the nursing component payment rate (by the GAO).

Home Health Agencies

Delayed the effective date of the 15 percent reduction on payment limits for home health services an additional year after the implementation of PPS. Also provided the Secretary can adjust for case mix changes that are not the result of real case mix changes. Provided home health agencies with the full market basket

update for FY 2001. Provided a temporary 10 percent increase in payment for home health services furnished in a rural area from April 1, 2001 until March 31, 2003. Provided a two-month periodic interim payment after PPS began and subject to repayment with the settlement of the last cost report filed before PPS. Clarified that home health agencies are not prevented from using telehealth services if the services do not substitute for in-person home health services ordered under a plan of care and are not considered a home health visit for eligibility or payment purposes. Prohibited the Secretary from using solely time or distance in determining branch office status and permitted the Secretary to include forms of technology in determining what constitutes supervision for purposes of determining branch office status. Clarified the definition of homebound to permit beneficiaries who require home health services to attend adult day care for therapeutic, psychosocial, or medical treatment and remain eligible for the home health benefit. Also clarifies that any absence for the purpose of attending a religious services is considered infrequent or of short duration.

Hospices

Increased the hospice update by 5.0 percentage points in FY 2001 and required the Secretary to use 1.0043 as the Wichita, Kansas hospice wage index for FY 2000. Clarified that certification of an individual's terminal illness must be based on the physician's or the medical director's clinical judgment regarding the normal course of the individual's illness. Also required the Secretary to study and report on the appropriateness of the certification process regarding terminal illness and any recommendations for legislation by two years after enactment.

Hospital outpatient departments

Limited the amount of a beneficiary's copayment for a procedure in a hospital outpatient department (HOPD) to the hospital inpatient deductible applicable in that year, effective April 1, 2001. Reduced the effective copayment rate for outpatient services to a maximum rate of 57 percent and then gradually reduced the effective coinsurance rate in 5 percentage point intervals from 2002 through 2006 until the maximum rate is 40 percent in 2006, starting in April 2001. Increased the 2001 update to the full rate of increase in the market basket index. Increased the 2001 outpatient PPS rates. Authorized the Secretary to adjust the conversion factor in later years to eliminate the effect of coding or classification changes. Modified the procedures and standards by which certain medical devices are categorized and determined eligible for pass-through payments under the PPS. Permitted all qualifying hospitals to be eligible for transitional payments under OPPS. Established that existing provider-based status designations continue for 2 years beginning October 1, 2000. Established that children's hospitals would not receive lower Medicare payments under the outpatient PPS system than they would have received under the prior payment system.

Ambulatory surgical centers

Delayed implementation of proposed regulatory changes to the ambulatory

payment classification system, which are based on 1994 cost data, until January 1, 2002. Established that the these changes would be phased in over 4 years. Required that the revised payment system, based on 1999 (or later) cost data, be implemented January 1, 2003. Established that the phase-in of the revised system and 1994 data ends when the system with 1999 or later data is implemented.

Preventive Benefits

Made the following changes to coverage of preventive services: 1) modified existing law to provide Medicare coverage for biennial screening Pap smears and pelvic exams; 2) added Medicare coverage for annual glaucoma screenings for persons determined to be at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes; 3) authorized coverage for screening colonoscopies for all individuals, not just those at high risk; 4) specified that screening mammographies are paid under the physician fee schedule; and 5) authorized coverage for medical nutrition therapy services for beneficiaries who have diabetes or renal disease.

Immunosuppressive Drugs

Eliminated the time limitations of the coverage of immunosuppressive drugs for beneficiaries who have received a transplant paid for by Medicare.

Persons with Amyotrophic Lateral Sclerosis

Waived the 24-month waiting period for Medicare coverage (otherwise applicable for disabled persons) for persons with amyotrophic lateral sclerosis (ALS).

Ambulances

Provided for the full inflation update in 2001. Increased payments (from July 1, 2001 - December 31, 2003) for ground ambulance trips originating in rural areas that are greater than 17 miles and up to 50 miles.

Therapy Services

Extended the moratorium on physical therapy and occupational therapy caps for an additional year through 2002.

Renal Dialysis

Increased the composite rate payment for renal dialysis by 2.4 percent for 2001. The Secretary was required to collect data and develop an end-stage renal disease (ESRD) market basket whereby the Secretary could estimate, before the beginning of each year, the percentage increase in costs for the mix of labor and non-labor goods and services included in the composite rate. The Secretary was required to report to Congress on the index together with recommendations on the appropriateness of an annual or periodic update.

Durable Medical Equipment and Prosthetics and Orthotics

Provided full CPI-U update for DME and PO for 2001, but maintained for 2002 the 0 percent update for DME and 1 percent update for PO. Provided coverage for certain prosthetics and custom-fabricated orthotics. Provided coverage for replacement of certain artificial limbs and replacement parts for such limbs.

Revisions to Medicare Coverage Process

Clarified when and under what circumstances Medicare coverage policy could be challenged. An aggrieved party could file a complaint concerning a national coverage decision which would be reviewed by the Department Appeals Board (DAB) of HHS. An aggrieved party could also file a complaint concerning a local coverage determination. In this case, the determination would first be reviewed by an administrative law judge. If unsatisfied, complainants could subsequently seek review of such local policy by the DAB. In both cases, a DAB decision would constitute final HHS action and be subject to judicial review. An affected party would be permitted to submit a request to the Secretary to issue a national coverage or noncoverage determination.

Medicare+Choice

Established multiple floor rates, based on population and location. Applied a 3 percent minimum update in 2001 and returned to the current law minimum update of 2 percent thereafter. Increased the M+C payment rates for enrollees with ESRD to reflect the demonstration rate of social health maintenance organizations' ESRD capitation demonstrations. Extended the current risk adjustment methodology until 2003 and beginning in 2004, begin to phase in a new risk adjustment methodology based on data from inpatient hospitals and ambulatory settings. Permitted M+C plans to offer reduced Medicare Part B premiums to their enrollees as part of providing any required additional benefits or reduced cost-sharing. Extended the application of the new entry bonus for M+C plans to include areas for which notification had been provided, as of October 3, 2000, that no plans are available January 1, 2001. Required payment adjustments to M+C plans if a legislative change resulted in significant increased costs. Precluded the Secretary from implementing, other than at the beginning of a calendar year, regulations that impose new, significant regulatory requirements on M+C organizations. Required the Secretary to make decisions, within 10 days, approving or modifying marketing material used by M+C organizations, provided that the organization used model language specified by the Secretary. Allowed an M+C organization offering a plan in an area with more than one local coverage policy to use the local coverage policy for the part of the area that was most beneficial to M+C enrollees (as identified by the Secretary) for all M+C enrollees enrolled in the plan. Expanded the M+C quality assurance programs for M+C plans to include a separate focus on racial and ethnic minorities. Allowed the Secretary to waive or modify requirements that hinder the design of, offering of, or enrollment in certain M+C plans, such as M+C plans under contract between M+C organizations and employers, labor

organizations, or trustees of a fund established by employers and/or labor organizations. Extended the period for Medigap enrollment for certain M+C enrollees affected by termination of coverage. Allowed individuals who enroll in an M+C plan after the 10th day of the month to receive coverage beginning on the first day of the next calendar month. Permitted ESRD beneficiaries to enroll in another M+C plan if they lost coverage when their plan terminated its contract or reduced its service area. Required an M+C plan to cover post-hospitalization skilled nursing care through an enrollee's "home skilled nursing facility" in certain situations. Mandated review of ACR submissions by the HCFA Chief Actuary.

PUBLIC HEALTH SECURITY AND BIOTERRORISM PREPAREDNESS AND RESPONSE ACT (P.L. 107-188)

Medicare+Choice

Moved CMS' annual announcement of M+C payment rates from no later than March 1 to no later than the 2nd Monday in May, effective only in 2003 and 2004. Temporarily moved the deadline for plans to submit information about ACRs, M+C premiums, cost sharing, and additional benefits (if any) from no later than July 1 to no later than the 2nd Monday in September in 2002, 2003, and 2004. Changed the annual coordinated election period from the month of November to November 15th through December 31 in 2002, 2003, and 2004. Allowed Medicare beneficiaries to make and change elections to an M+C plan on an ongoing basis through 2004. Then beginning in 2005, individuals will only be able to make changes on the more limited basis, originally scheduled to be phased in beginning in 2002.

CONSOLIDATED APPROPRIATIONS RESOLUTION, 2003 (CAR) (P.L.108-7)

Hospitals

Temporarily increased the base rate used to pay rural and small urban hospitals to that used to pay hospitals in large urban areas for discharges from April 1, 2003 to September 30, 2003.

Physicians

Permitted CMS to make adjustments to sustainable growth rate figures for previous years, thereby permitting a fee schedule update of 1.6 percent for 2003.

Part B Premium

Extended through 2003 a program that pays the Medicare Part B premium for Medicare beneficiaries with incomes between 120 percent and 135 percent of poverty.

TO EXTEND THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES BLOCK GRANT PROGRAM, AND CERTAIN TAX AND TRADE PROGRAMS, AND FOR OTHER PURPOSES (P.L. 108-89)

Hospitals

Extended Medicare's payment equalization between large urban hospitals and other hospitals for discharges through March 31, 2004. The law which became effective October 1, 2003 requires the Secretary to equalize the base amounts by November 1, 2003 and compensate hospitals for missed payments.

CBO SAVINGS AND REVENUE ESTIMATES FOR BUDGET RECONCILIATION AND RELATED ACTS, 1981-2003

Table 2-45 shows estimates of savings and revenue increases for budget reconciliation legislation enacted from 1981 to 1997 and spending increases enacted in 1999, 2000 and 2003. These estimates were made at the time of enactment by the Congressional Budget Office (CBO). It should be noted that the estimates are compared with the CBO budget baseline in effect at the time. The savings from the various reconciliation bills cannot be added together.

TABLE 2-45--MEDICARE SAVINGS ESTIMATES, 1981-2003

[In Billions of Dollars]

Legislative Act	Savings
Omnibus Budget Reconciliation Act of 1981:	
Spending reductions for fiscal years 1982-84	$4.3
Tax Equity and Fiscal Responsibility Act of 1982:	
Spending reductions for fiscal years 1983-87	23.1
Social Security Amendments of 1983:	
Spending reductions for fiscal years 1983-88	0.2
Revenue increases for fiscal years 1983-88	11.5
Deficit Reduction Act of 1984:	
Spending reductions for fiscal years 1984-87	6.1
Consolidated Omnibus Budget Reconciliation Act of 1985:	
Spending reductions for fiscal years 1986-81	12.6
Omnibus Budget Reconciliation Act of 1986:	
Spending reductions for fiscal years 1987-89	1.0
Omnibus Budget Reconciliation Act of 1987:	
Spending reductions for fiscal years 1988-90	9.8
Omnibus Budget Reconciliation Act of 1989:	
Spending reductions for fiscal years 1990-94	10.9
Omnibus Budget Reconciliation Act of 1990:	
Spending reductions for fiscal years 1991-95	43.1
Revenue increases for fiscal years 1991-95	26.9
Omnibus Budget Reconciliation Act of 1993:	
Spending reductions for fiscal years 1994-98	55.8
Revenue increases for fiscal years 1994-98	53.8

TABLE 2-45--MEDICARE SAVINGS ESTIMATES, 1981-2003-continued

[In Billions of Dollars]

Legislative Act	Savings
Health Insurance Portability and Accountability Act of 1996:	
Spending reductions for fiscal years 1996-2002	3.0
Balanced Budget Act of 1997:	
Spending reductions for fiscal years 1998-2002	116.4
Spending reductions for fiscal years 1998-2007	393.8
Balanced Budget Refinement Act of 1999:	
Spending increases for fiscal years 2000-2004	-15.0
Spending increases for fiscal years 2004-9	-25.1
Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000	
Spending increase for fiscal years 2000-2005	-32.3
Spending increase for fiscal years 2001-2010	-81.5
Consolidated Appropriations Resolution, 2003	
Spending increase for 2003	-1.1
Spending increase for 2003-2013	-53.5

Note-Savings relative to baseline at time of enactment. Figures cannot be summed.

Sources: Committee on Ways and Means (1998); Congressional Budget Office.

MEDICARE HISTORICAL DATA

Tables 2-46 through 2-52 present detailed historical data on the Medicare Program. Tables 2-46 and 2-47 present detailed enrollment data. Table 2-48 describes the percentage of enrollees participating in a State buy-in agreement. Tables 2-49, 2-50 and 2-51 show the number of persons served and program payments. Table 2-52 shows the utilization of short stay hospital services.

TABLE 2-46--GROWTH IN NUMBER OF AGED MEDICARE ENROLLEES BY SEX AND AGE, SELECTED YEARS 1968-2001

Sex and Age	1968	1975	1980	1985	1990	1995	2000	2001	Average Annual Growth Rate (Percent)				Total Aged Population 2001[1]	Enrollees as Percent of Total Aged Population 2001
									1968-1975	1975-1984	1985-1995	1995-2001		
All Persons	19,496	22,548	25,515	28,175	30,948	33,142	34,253	34,477	2.1	2.3	1.6	0.7	35,064	98.3
65-69	6,551	7,642	8,459	8,956	9,695	9,517	9,167	9,201	2.2	1.6	0.6	-0.6	9,411	97.8
70-74	5,458	5,950	6,756	7,442	7,951	8,756	8,609	8,564	1.2	2.3	1.6	-0.4	8,744	97.9
75-79	3,935	4,313	4,809	5,453	6,058	6,563	7,285	7,285	1.3	2.4	1.9	1.8	7,401	98.4
80-84	2,249	2,793	3,081	3,463	3,957	4,470	4,870	5,022	3.1	2.2	2.6	2.0	5,070	99.1
85 +	1,303	1,850	2,410	2,861	3,286	3,837	4,322	4,390	5.1	4.6	3.0	2.3	4,437	98.9
Males	8,177	9,201	10,268	11,282	12,416	13,434	14,112	14,262	1.7	2.0	2.0	1.5	14,199	97.2
65-69	2,944	3,420	3,788	4,019	4,352	4,348	4,268	4,298	2.2	1.6	1.6	0.2	4,393	96.3
70-74	2,322	2,504	2,841	3,155	3,406	3,791	3,812	3,813	1.1	2.4	2.4	1.4	3,857	99.0
75-79	1,596	1,669	1,854	2,112	2,382	2,642	2,991	3,003	0.6	2.4	2.4	2.4	2,997	96.0
80-84	864	1,005	1,062	1,188	1,369	1,593	1,804	1,876	2.2	1.6	1.6	2.9	1,764	97.4
85 +	450	604	722	809	906	1,060	1,237	1,272	4.3	3.1	3.1	2.9	1,188	97.6
Females	11,319	13,347	15,247	16,894	18,532	19,708	20,140	20,199	2.4	2.4	2.4	1.2	20,203	99.0
65-69	3,606	4,222	4,671	4,938	5,343	5,169	4,898	4,903	2.3	1.5	1.5	-9.9	5,201	95.1
70-74	3,136	3,446	3,914	4,287	4,545	4,964	4,797	4,751	1.4	2.3	2.3	-10.0	4,945	99.2
75-79	2,338	2,644	2,954	3,341	3,676	3,921	4,294	4,281	1.8	2.4	2.4	-11.1	4,221	99.0
75-84	1,386	1,788	2,019	2,276	2,588	2,877	3,066	3,145	3.7	2.4	2.4	-14.0	2,970	100.7
85 +	853	1,246	1,689	2,053	2,380	2,777	3,085	3,119	5.6	5.3	5.3	-14.0	2,866	103.8

[1] Total aged population data reflect United States residents.

Note-Totals may not add due to rounding.

Source: Centers for Medicare & Medicaid Services, Office of Research, Development and Information, U.S. Department of Commerce, Bureau of the Census.

TABLE 2-47--GROWTH IN NUMBER OF DISABLED MEDICARE ENROLLEES WITH HOSPITAL INSURANCE COVERAGE BY TYPE OF ENTITLEMENT AND AGE, SELECTED YEARS 1975-2001

Type of Entitlement and Age	Year							Average Annual Percent Growth		
	1975	1980	1985	1990	1995	2000	2001	1975-1985	1985-1995	1995-2001
All Disabled Persons	2,058,424	2,425,231	2,906,876	3,254,983	4,393,287	5,366,598	5,562,860	3.5	4.2	4.0
Under 35	238,070	193,392	400,268	483,262	587,709	522,123	520,537	5.3	3.9	-2.0
35-44	251,142	258,374	442,809	654,953	973,328	1,129,170	1,137,135	5.8	8.2	2.6
45-54	508,345	572,823	593,058	741,193	1,187,993	1,627,107	1,727,260	1.6	7.2	6.4
55-64	1,060,967	1,400,642	1,470,741	1,375,575	1,644,257	2,088,198	2,177,928	3.3	1.1	4.8
All Disabled Workers	1,638,662	2,396,897	2,325,525	2,579,097	3,602,559	NA	NA	3.6	4.5	NA
Under 35	100,439	184,619	201,678	257,760	357,794	NA	NA	7.2	5.9	NA
35-44	164,439	253,186	308,068	482,071	769,071	NA	NA	6.5	9.6	NA
45-54	426,451	565,846	492,809	612,692	1,023,616	NA	NA	1.5	7.6	NA
55-64	947,333	1,393,246	1,322,970	1,226,574	1,452,078	NA	NA	3.4	0.9	NA
Adults Disabled as Children	324,864	409,072	467,634	542,416	609,081	NA	NA	3.7	2.7	NA
Under 35	153,708	173,684	189,109	208,901	213,973	NA	NA	2.1	1.2	NA
35-44	84,508	105,092	128,941	158,725	189,108	NA	NA	4.3	3.9	NA
45-54	71,484	80,381	88,584	107,092	132,484	NA	NA	2.2	4.1	NA
55-64	45,164	49,910	61,000	67,698	73,516	NA	NA	3.1	1.9	NA
Widows and Widowers	83,771	110,785	82,841	68,793	111,121	NA	NA	-0.1	3.0	NA
Under 55	7,446	7,577	4,585	5,615	12,420	NA	NA	-4.7	10.5	NA
55-64	76,325	103,208	78,255	63,178	98,701	NA	NA	0.3	2.3	NA
End-Stage Renal Disease Only	11,127	28,334	30,786	64,677	70,526	NA	NA	10.7	8.6	NA
Under 35	3,729	8,773	9,391	16,601	15,942	NA	NA	9.7	5.4	NA
35-44	2,187	5,188	5,799	14,157	15,149	NA	NA	10.2	10.1	NA
45-54	2,966	6,977	7,080	15,794	19,473	NA	NA	9.1	10.6	NA
55-64	2,245	7,396	8,516	18,125	19,962	NA	NA	14.3	8.9	NA

Note-Data are no longer available by the historical breakdowns.

Source: Centers for Medicare & Medicaid Services, Office of Research, Development, and Information, unpublished data.

TABLE 2-48--NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE (SMI) UNDER STATE BUY-IN AGREEMENTS BY TYPE OF BENEFICIARY AND BY YEAR OR 2001 AREA OF RESIDENCE

Year or Area of Residence [1]	All Persons		Aged		Disabled		
	Number in Thousands	Percent of SMI Enrolled	Number in Thousands	Percent of SMI Enrolled	Total SMI in Thousands	Number in Thousands	Percent of SMI Enrolled
1968	1,648	8.8	1,648	8.8	--	NA	NA
1975	2,846	12.0	2,483	11.4	--	363	18.7
1980	2,954	10.9	2,449	10.0	--	504	18.9
1985	2,670	9.0	2,164	8.0	--	505	19.2
1990	3,604	11.0	2,714	9.1	2,943	890	30.0
1991	3,766	10.4	2,817	8.7	NA	949	27.8
1992	4,055	12.0	2,972	9.7	3,220	1,083	33.6
1993	4,353	12.6	3,122	10.0	3,466	1,231	35.5
1994	4,625	13.2	3,243	10.3	3,720	1,382	37.2
1995	4,895	13.7	3,369	10.6	3,942	1,526	38.7
1996	5,001	13.1	3,404	10.6	4,155	1,597	38.4
1997	5,089	13.2	3,445	10.7	4,296	1,644	38.3
1998	5,109	13.9	3,492	10.8	4,486	1,775	39.6
1999	5,392	14.6	3,563	11.0	4,642	1,829	39.4
2000	5,549	14.8	3,632	11.1	4,768	1,917	40.2
2001	5,744	15.2	3,714	11.3	4,934	2,030	41.1
Area of Residence [1]							
All Areas	5,744	15.2	3,714	11.3	4,934	2,030	41.1
United States	5,716	15.4	3,693	11.4	4,830	2,023	41.9
Alabama	144	21.6	93	17.1	124	51	41.1
Alaska	9	22.0	5	14.7	7	4	57.1
Arizona	67	10.2	42	7.2	78	25	32.1
Arkansas	81	19.5	53	15.5	74	28	37.8
California	857	22.9	624	18.8	428	233	54.4
Colorado	58	12.8	36	9.1	58	22	37.9
Connecticut	58	11.8	35	8.0	53	23	43.4
Delaware	13	11.7	8	8.2	13	5	38.5
D.C.	14	21.2	10	17.5	9	4	44.4
Florida	368	13.3	250	10.1	297	118	39.7
Georgia	187	20.8	121	16.3	160	66	41.3
Hawaii	22	13.8	16	11.0	13	6	46.2
Idaho	19	11.7	10	6.9	19	9	47.4
Illinois	167	10.8	99	7.2	176	68	38.6
Indiana	97	11.9	56	7.9	106	41	38.7
Iowa	54	11.8	32	7.8	47	22	46.8
Kansas	42	11.4	25	7.6	39	17	43.6
Kentucky	121	20.2	71	14.9	125	50	40.0
Louisiana	118	20.6	77	16.2	100	41	41.0
Maine	39	18.7	21	11.9	32	18	56.3
Maryland	71	11.7	46	8.5	68	25	36.8
Massachusetts	161	18.2	90	11.7	116	71	61.2
Michigan	150	11.1	82	7.0	182	68	37.4
Minnesota	70	11.1	41	7.3	64	29	45.3

TABLE 2-48--NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE (SMI) UNDER STATE BUY-IN AGREEMENTS BY TYPE OF BENEFICIARY AND BY YEAR OR 2001 AREA OF RESIDENCE- Continued

Year or Area of Residence [1]	All Persons		Aged		Disabled		
	Number in Thousands	Percent of SMI Enrolled	Number in Thousands	Percent of SMI Enrolled	Total SMI in Thousands	Number in Thousands	Percent of SMI Enrolled
Mississippi	119	29.2	77	24.1	88	42	47.7
Missouri	94	11.4	54	7.6	116	40	34.5
Montana	13	9.8	7	6.0	17	6	35.3
Nebraska	22	9.0	11	5.0	25	11	44.0
Nevada	23	9.6	14	6.6	29	9	31.0
New Hampshire	10	6.3	5	3.5	19	5	26.3
New Jersey	151	13.2	103	10.1	124	48	38.7
New Mexico	40	17.9	27	14.1	32	13	40.6
New York	395	15.6	272	12.3	329	123	37.4
North Carolina	234	21.0	152	16.4	187	82	43.9
North Dakota	7	7.1	4	4.5	9	3	33.3
Ohio	182	11.1	114	7.9	201	68	33.8
Oklahoma	70	14.3	46	10.9	66	24	36.4
Oregon	65	13.6	39	9.2	56	26	46.4
Pennsylvania	219	11.0	129	7.3	207	90	43.5
Rhode Island	7	4.5	4	2.9	20	3	15.0
South Carolina	120	21.4	75	16.3	101	45	44.6
South Dakota	13	11.5	8	7.9	12	5	41.7
Tennessee	184	22.8	109	16.4	142	75	52.8
Texas	381	17.3	281	14.6	268	100	37.3
Utah	18	9.1	9	5.1	21	9	42.9
Vermont	14	16.3	8	10.8	12	6	50.0
Virginia	119	13.8	75	10.1	123	44	35.8
Washington	98	13.8	56	9.0	85	42	49.4
West Virginia	49	14.9	27	10.3	65	22	33.8
Wisconsin	75	10.1	40	6.0	80	35	43.8
Wyoming	7	10.9	4	7.0	7	3	42.9
Puerto Rico	7	1.7	4	1.3	97	3	3.1
Other/Unknown [2]	5	1.1	4	1.1	104	0	0.0

[1] State of residence is not necessarily State that bought coverage.

[2] Includes Guam, Virgin Islands, and foreign countries; data for these areas combined to prevent disclosure of confidential information.

NA-Not available

Source: Centers for Medicare & Medicaid Services, unpublished data.

TABLE 2-49--DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS BY TYPE OF COVERAGE, TYPE OF SERVICE, AND TYPE OF ENROLLEE, CALENDAR YEAR 2002

[Amounts in millions of dollars]

Type of Coverage and Service	All Enrollees		Aged		Disabled	
	Amount	Percentage Distribution	Amount	Percentage Distribution	Amount	Percentage Distribution
HI	$148,523	100.0	$128,663	100.0	$19,860	100.0
Inpatient	104,908	70.6	88,052	68.4	16,856	84.9
SNF	14,646	9.9	13,831	10.7	815	4.1
HHA	5,138	3.5	4,644	3.6	494	2.5
Hospice	4,628	3.1	4,397	3.4	231	1.2
Managed Care	19,203	12.9	17,739	13.8	1,464	7.4
SMI	112,042	100.0	95,122	100.0	16,920	100.0
Physicians Fee Schedule	44,979	40.1	38,992	41.0	5,987	35.4
Durable Medical Equipment	6,530	5.8	5,188	5.5	1,342	7.9
Carrier Laboratory	2,770	2.5	2,346	2.5	424	2.5
Other Carrier	10,735	9.6	9,204	9.7	1,530	9.0
Outpatient Hospital	13,139	11.7	10,846	11.4	2,292	13.5
HHA	5,416	4.8	4,909	5.2	507	3.0
Intermediary Laboratory	2,288	2.0	1,859	2.0	429	2.5
Other Intermediary	8,689	7.7	5,435	5.7	3,254	19.2
Managed Care	17,497	15.6	16,342	17.2	1,155	6.8
Total	260,565	100.0	223,785	100.0	36,780	100.0

HI- Hospital Insurance.

SMI- Supplementary Medical Insurance.

SNF- Skilled Nursing Facility.

HHA- Home Health Agency.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

TABLE 2-50--PERSONS ENROLLED AND PERSONS SERVED UNDER MEDICARE, AND PROGRAM PAYMENTS, BY TYPE OF COVERAGE AND SERVICE, SELECTED CALENDAR YEARS 1967-2000

Type of Coverage and Service	Year					Average Annual Rate of Change		
	1967	1980	1990	1995	2000	1967-1980	1980-1990	1990-2000
	Number of Enrollees (In Thousands)							
HI and/or SMI	19,521	28,478	34,213	37,566	39,632	2.9	1.9	1.5
HI	19,494	28,067	33,731	37,152	39,211	2.8	1.9	1.5
SMI	17,893	27,400	32,636	35,711	37,369	3.3	1.8	1.4
	Number of Persons Served (In Thousands)							
HI	3,960	6,752	7,036	7,886	7,325	4.2	0.4	0.4
Inpatient	3,601	6,672	6,543	6,938	6,917	4.9	-0.2	0.6
SNF	354	257	638	1,063	1,468	-2.4	9.5	8.7
HHA	126	726	1,936	3,152	1,444	14.4	10.3	-2.9
Hospice	NA	NA	NA	NA	541	NA	NA	NA
SMI	6,523	17,822	26,951	29,912	29,313	8.0	4.2	0.8

TABLE 2-50--PERSONS ENROLLED AND PERSONS SERVED UNDER MEDICARE, AND PROGRAM PAYMENTS, BY TYPE OF COVERAGE AND SERVICE, SELECTED CALENDAR YEARS 1967-2000- continued

Type of Coverage and Service	Year					Average Annual Rate of Change		
	1967	1980	1990	1995	2000	1967-1980	1980-1990	1990-2000
Physician and Other Medical Services	6,415	17,258	26,350	29,222	28,763	7.9	4.3	0.9
Outpatient Services	1,511	7,538	15,511	18,945	21,029	13.2	7.5	3.1
HHA	118	327	38	37	1,190	8.2	-19.4	41.1
Total	7,154	18,031	30,087	30,423	29,583	7.4	5.3	-0.2
Rate Per Thousand Enrollees								
HI	203	241	209	239	187	1.3	-1.4	-1.1
Inpatient	185	238	194	207	185	2.0	-2.0	-0.5
SNF	18	9	19	37	37	-5.2	7.8	7.0
HHA	6	26	57	102	37	11.9	8.2	-4.3
Hospice	NA	NA	NA	NA	14	NA	NA	NA
SMI	365	650	826	939	784	4.5	2.4	-0.5
Physician and Other Medical Services	359	630	807	917	770	4.4	2.5	-0.5
Outpatient Services	84	275	475	612	563	9.6	5.6	1.7
HHA	7	12	1	1	32	4.2	-22.0	41.4
Total	366	633	792	893	746	4.3	2.3	-0.6
Program Payments (In Millions of Dollars)								
HI	2,967	23,119	62,347	101,835	101,663	17.1	10.4	5.0
Inpatient	2,667	22,297	56,716	78,944	85,197	17.7	9.8	4.2
SNF	274	344	1,971	7,799	10,621	1.8	19.1	18.3
HHA	26	478	3,660	15,092	2,918	25.1	22.6	-2.2
Hospice	NA	NA	NA	NA	2,927	NA	NA	NA
SMI	1,272	10,494	39,072	57,145	72,599	17.6	14.0	6.4
Physician and Other Medical Services	1,217	8,358	30,222	41,617	51,474	16.0	13.7	5.5
Outpatient Services	38	1,962	8,773	15,328	16,787	35.4	16.2	6.7
HHA	17	175	78	200	4338	19.6	-7.8	49.5
Total	4,239	33,613	101,419	158,980	174,261	17.3	11.7	5.6
Program Payments Per Person Served								
HI	749	3,424	8,861	12,672	13,878	12.4	10.0	4.6
Inpatient	741	3,342	8,688	11,336	12,318	12.3	10.0	3.6
SNF	774	1,339	3,089	6,325	7,235	4.3	8.7	8.9
HHA	206	658	1,690	4,404	2,021	9.3	9.9	1.8
Hospice	NA	NA	NA	NA	5,409	NA	NA	NA
SMI	195	589	1,450	1,889	2,477	8.9	9.4	5.5
Physician and Other Medical Services	190	484	1,147	1,409	1,790	7.5	9.0	4.6
Outpatient Services	25	260	566	778	798	19.7	8.1	3.5
HHA	144	535	2,053	4,837	3,644	10.6	14.4	5.9
Total	593	1,864	3,743	5,226	5,891	9.2	7.2	4.6

HI- Hospital Insurance.

SMI- Supplementary Medical Insurance.

SNF- Skilled Nursing Facility.

TABLE 2-50--PERSONS ENROLLED AND PERSONS SERVED UNDER MEDICARE, AND PROGRAM PAYMENTS, BY TYPE OF COVERAGE AND SERVICE, SELECTED CALENDAR YEARS 1967-2000- continued

HHA- Home Health Agency.

Source: Centers for Medicare & Medicaid Services, Office of Research, Development, and Information.

TABLE 2-51--PERSONS SERVED AND PROGRAM PAYMENTS FOR MEDICARE BENEFICIARIES, BY DEMOGRAPHIC CHARACTERISTICS, CALENDAR YEAR 2000

Demographic Characteristic	Persons Served		Program Payments			
	Number in Thousands	Percent	Amount in Millions	Percent	Average Amount Per Person Served	Per Enrollee
Sex:						
Male	12,109	40.9	$76,230	43.7	$6,295	$5,370
Female	17,473	59.1	98,031	56.3	5,610	5,286
Age:						
Under 65 Years	4,096	13.8	25,773	14.8	6,292	5,252
65-74 Years	12,128	41.0	57,494	33	4,741	4,040
75-84 Years	9,620	32.5	62,685	36	6,516	6,320
85 Years or Older	3,783	12.6	28,309	16.2	7,573	7,684
Race:						
White	25,534	86.3	144,417	82.9	5,656	5,184
Nonwhite	3,953	13.4	29,303	16.8	7,413	6,125
Unknown	95	0.3	542	0.3	5,705	5,693
Type of Entitlement:						
Aged	25,486	86.2	148,488	85.2	5,826	5,335
Disabled	4,096	13.8	25,773	14.8	6,292	5,252
MSA Type:						
Urban	21,009	71.0	131,348	75.4	6,252	5,579
Rural	8,574	29	42,913	24.6	5,005	4,666

Source: Centers for Medicare & Medicaid Services.

TABLE 2-52--USE OF SHORT-STAY HOSPITAL SERVICES BY MEDICARE ENROLLEES BY CALENDAR YEAR OR 2001 DEMOGRAPHIC CHARACTERISTICS

Calendar Year or Characteristic	Hospital Insurance Enrollees in Thousands	Discharges		Total Days of Care			Program Payments			
		Number in Thousands	Per 1,000 Enrollees	Number in Thousands	Per Discharge	Per 1,000 Enrollees	Amount in Millions	Per Discharge	Per Covered Day of Care	Per Enrollee
1975	24,640	8,001	325	89,275	11.2	3,623	$9,748	$1,218	$109	$396
1980	28,067	10,279	366	109,175	10.6	3,890	22,099	2,150	202	787
1982	29,069	11,109	382	113,047	10.2	3,889	30,601	2,755	271	1,053
1984	29,996	10,896	363	96,485	8.9	3,217	38,500	3,533	399	1,284
1985	30,589	10,027	328	86,339	8.6	2,823	40,200	4,009	466	1,314
1986	31,216	10,044	322	86,910	8.7	2,784	41,781	4,160	481	1,338
1987	31,853	10,110	317	89,651	8.9	2,815	44,068	4,359	492	1,383
1988	32,483	10,256	316	90,873	8.9	2,798	46,879	4,571	516	1,443
1989	33,040	10,148	307	89,902	8.9	2,721	49,091	4,838	546	1,486
1990	33,719	10,522	312	92,735	8.8	2,750	53,708	5,281	579	1,593
1991	34,428	10,737	312	93,935	8.7	2,728	58,750	5,610	625	1,706
1992	35,154	10,958	312	91,990	8.4	2,617	64,810	6,057	705	1,844
1993	35,904	10,979	306	87,883	8.0	2,448	67,260	6,257	765	1,873
1994	36,543	11,282	309	84,742	7.5	2,319	70,624	6,377	833	1,933
1995	37,135	11,435	308	80,056	7.0	2,156	74,836	6,656	935	2,015
1996[1]	33,301	11,474	345	75,660	6.6	2,272	78,546	6,953	1,038	2,359
1997[1]	32,614	11,527	353	73,029	6.3	2,239	80,725	7,118	1,105	2,475
1998[1]	31,955	11,355	355	70,055	6.2	2,192	78,364	7,021	1119	2,452
1999[1]	31,777	11,605	365	70,508	6.1	2,219	79,013	6,920	1,121	2,486
2000[1]	32,329	11,720	363	70,330	6.0	2,175	81,231	6,971	1,155	2,513
2001[1]	33,446	12,231	366	72,607	5.9	2,171	88,323	7,262	1,216	2,641
Annual Percentage Change in Period:										
1975-1984	2.2	3.5	1.3	0.9	-2.5	-1.3	16.5	12.6	15.5	14.0
1985-1995	2.0	-1.3	-3.1	-1.3	-1.6	-3.2	6.3	6.1	7.6	4.2

TABLE 2-52--USE OF SHORT-STAY HOSPITAL SERVICES BY MEDICARE ENROLLEES BY CALENDAR YEAR OR 2001 DEMOGRAPHIC CHARACTERISTICS-continued

Calendar Year or Characteristic	Hospital Insurance Enrollees in Thousands	Discharges		Total Days of Care			Program Payments			
		Number in Thousands	Per 1,000 Enrollees	Number in Thousands	Per Discharge	Per 1,000 Enrollees	Amount in Millions	Per Discharge	Per Covered Day of Care	Per Enrollee
1996-2001	0.1	1.3	1.2	-0.8	-2.1	-0.9	2.4	0.9	3.2	2.3
Age:										
Less Than 65	5,172	1,899	364	11,874	6.5	2,296	13,264	7,098	1,117	2,565
65-69	7,695	1,698	230	9,519	5.9	1,237	13,199	7,825	1,387	1,715
70-74	6,994	2,026	303	11,485	6.0	1,642	15,699	7,784	1,367	2,245
75-79	6,021	2,265	393	13,330	6.3	2,214	17,177	7,609	1,289	2,853
80-84	4,190	2,029	487	12,285	6.5	2,932	14,421	7,125	1,174	3,442
85 or Older	3,787	2,314	610	14,114	6.5	3,727	14,564	6,308	1,032	3,846
Sex:										
Male	14,616	5,208	371	31,346	6.0	2,145	40,971	7,816	1,307	2,803
Female	19,113	6,712	361	41,261	6.1	2,159	47,352	6,842	1,148	2,477
Race: [2]										
White	28,571	10,078	361	59,089	5.9	2,068	72,375	7,123	1,225	2,533
All Other	4,875	1,766	388	13,186	7.5	2,705	15,549	7,990	1,179	3,190
Area of Residence:										
Northeast	6,650	2,388	359	16,296	6.8	2,503	20,856	8,791	1,280	3,204
North Central	8,412	3,154	375	17,478	5.5	2,088	21,295	6,790	1,218	2,544
South	12,708	4,969	391	29,071	5.9	2,301	32,676	6,608	1124	2,587
West	5,225	1,568	300	8,720	5.6	1,725	13,002	8,346	1,491	2,572

[1] Prior to 1996, data were obtained from the Annual Person Summary Record. Beginning in 1996, utilization rates are based on persons receiving fee-for-service care and total persons not enrolled in prepaid health plans.

[2] Excludes unknown race.

Source: Centers for Medicare & Medicaid Services, Office of Research, Development, and Information.

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