

HANYS Data Academy Data Fundamentals

Introduction to Medicare

Part II

April 2007



Provider Component	Hospital Outpatient
Federal Rate	Conversion Factor (per procedure)
Rate Year	Jan 1– Dec 30
Area Salary Adjustment / Labor Share	Wage Index @ 60%
Urban/ Rural Adjustment	7.1% Add-On for Sole Community Hospitals
Medical Education	None
Disproportionate Volume of Poor Patients	None
Intensity of Services	APCs – Ambulatory Payment Classification
Excessive Costs	Cost Outliers
Partial Treatment	None

Hospital Outpatient PPS



Hospital Outpatient PPS – The Core Issues

- **August 2000 – cost-based prior, now one federal rate for all hospitals:**
 - Called the Conversion Factor: \$61.468 per procedure in 2007.
 - Capital included in Conversion Factor.
- **The wage index is the same as hospital inpatient:**
 - Applied to 60% of the Conversion Factor
- **Payment groups are APCs – Ambulatory Payment Classification groups.**
 - Currently 862 APCs.



Hospital Outpatient PPS – Determination of APC

APC 0147 Weight: 8.5477 Level II Sigmoidoscopy and Anoscopy

HCPCS/CPT

45303	Proctosigmoidoscopy dilate
45305	Proctosigmoidoscopy w/bx
45308	Proctosigmoidoscopy removal
45309	Proctosigmoidoscopy removal
45315	Proctosigmoidoscopy removal
45317	Proctosigmoidoscopy bleed
45333	Sigmoidoscopy & polypectomy
45334	Sigmoidoscopy for bleeding
45338	Sigmoidoscopy w/tumr remove
45339	Sigmoidoscopy w/ablate tumr
45340	Sig w/balloon dilation
45341	Sigmoidoscopy w/ultrasound
45342	Sigmoidoscopy w/us guide bx
46604	Anoscopy and dilation
46608	Anoscopy, remove for body
46611	Anoscopy

APC 0146 Weight: 4.8683 Level I Sigmoidoscopy and Anoscopy

45300	Proctosigmoidoscopy dx
45330	Diagnostic sigmoidoscopy
45331	Sigmoidoscopy and biopsy
45332	Sigmoidoscopy w/fb removal
45335	Sigmoidoscopy w/submuc inj
45337	Sigmoidoscopy & decompress
46606	Anoscopy and biopsy
46614	Anoscopy, control bleeding

HCPCS - Healthcare Common Procedure Coding System

CPT - Current Procedural Terminology (American Medical Association)



Hospital Outpatient PPS – Other Critical Issues

- **Medical education / disproportionate volume of poor patients:** no payments.
- **Cost Outlier Payments:** same concept as inpatient operating.
- **Special Payment Rules:**
 - New technologies.
 - Transitional pass-through payments for new drugs and medical devices for 2 to 3 years.
- **Co-insurance:** transitioning to enrollee co-payments at 20% of APC payments.
- **Sole Community Hospitals:** Receive a 7.1% add-on to all OPSS payments (excluding drugs and biologicals).



Example - APC Payment for Hospital Outpatient PPS

Based on 2007 Final Rule

	New York City Hospital	Albany Hospital
Conversion Factor	\$61.47	\$61.47
Labor Share	60.0%	60.0%
Labor Share of Rate	\$36.88	\$36.88
Wage Index	1.3344	0.8849
Adjusted Labor Share	\$49.21	\$32.64
Non Labor Share	\$24.59	\$24.59
Wage-Adjusted Rate	\$73.80	\$57.22
APC 146 Weight	4.8683	4.8683
APC 146 Payment	\$359.29	\$278.58



Table 5: Medicare Outpatient PPS Utilization - Top 50 APCs

(Ranked by Total Payments)

New York

**Top 50
APCs**

APC Code	Description	2005 Weight	New York		
			2005 Volume	Total Pmts 2005	Percent of Total \$
Total of Top 50 APCs			9,637,544	\$867,880,906	65.4%
All Other APCs			6,215,168	\$458,782,251	34.6%
TOTALS			15,852,712	\$1,326,663,157	
246	Cataract Procedures with IOL Insert	23.33	45,669	\$66,180,706	5.0%
143	Lower GI Endoscopy	8.60	86,274	\$44,867,218	3.4%
283	Computerized Axial Tomography with Contrast Material	4.75	152,477	\$44,779,260	3.4%
612	High Level Emergency Visits	4.11	169,987	\$42,617,989	3.2%
80	Diagnostic Cardiac Catheterization	36.27	17,978	\$40,844,799	3.1%
332	Computerized Axial Tomography and Computerized Angiography without Contras	3.39	194,522	\$40,712,253	3.1%
260	Level I Plain Film Except Teeth	0.77	854,809	\$40,354,680	3.0%
601	Mid Level Clinic Visits	0.98	541,260	\$31,770,573	2.4%
600	Low Level Clinic Visits	0.90	530,728	\$30,804,944	2.3%
611	Mid Level Emergency Visits	2.39	195,303	\$28,638,132	2.2%
602	High Level Clinic Visits	1.40	271,727	\$22,736,970	1.7%
412	IMRT Treatment Delivery	5.43	63,135	\$21,979,147	1.7%
141	Level I Upper GI Procedures	8.07	42,138	\$20,642,471	1.6%
325	Group Psychotherapy	1.47	210,842	\$19,562,145	1.5%
301	Level II Radiation Therapy	2.18	135,057	\$18,135,832	1.4%
734	Injection, darbepoetin alfa (for non-ESRD), per 1 mcg	0.06	4,123,926	\$15,086,593	1.1%
154	Hernia/Hydrocele Procedures	28.08	8,568	\$14,912,265	1.1%
336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont	6.32	36,351	\$14,438,735	1.1%
120	Infusion Therapy Except Chemotherapy	1.96	117,547	\$14,021,885	1.1%
337	MRI and Magnetic Resonance Angiography without Contrast Material followed	9.17	23,291	\$13,317,703	1.0%
377	Level III Cardiac Imaging	7.05	29,831	\$12,844,547	1.0%
9119	Pegfilgrastim	42.97	5,241	\$12,833,065	1.0%
107	Insertion of Cardioverter-Defibrillator	315.25	638	\$12,338,657	0.9%
162	Level III Cystourethroscopy and other Genitourinary Procedures	23.02	8,606	\$12,274,787	0.9%
41	Level I Arthroscopy	28.03	6,789	\$12,003,268	0.9%
849	Rituximab	7.68	26,757	\$11,714,777	0.9%
207	Level III Nerve Injections	5.82	31,983	\$11,634,531	0.9%
610	Low Level Emergency Visits	1.35	130,020	\$10,795,012	0.8%
304	Level I Therapeutic Radiation Treatment Preparation	1.71	97,380	\$10,258,041	0.8%
333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material	5.62	30,629	\$10,224,715	0.8%
323	Extended Individual Psychotherapy	1.76	90,658	\$9,895,492	0.7%
267	Level III Diagnostic Ultrasound	2.43	66,988	\$9,734,605	0.7%
131	Level II Laparoscopy	42.75	3,731	\$9,613,145	0.7%
117	Chemotherapy Administration by Infusion Only	2.95	48,753	\$9,355,351	0.7%
269	Level III Echocardiogram Except Transesophageal	3.26	45,629	\$9,040,218	0.7%
343	Level II Pathology	0.43	344,998	\$9,029,766	0.7%
280	Level III Angiography and Venography except Extremity	20.17	7,249	\$8,761,681	0.7%
99	Electrocardiograms	0.38	374,928	\$8,726,487	0.7%
266	Level II Diagnostic Ultrasound	1.63	87,624	\$8,661,447	0.7%
654	Insertion/Replacement of a permanent dual chamber pacemaker	105.38	1,322	\$8,657,843	0.7%
42	Level II Arthroscopy	43.58	2,969	\$8,366,189	0.6%
88	Thrombectomy	36.03	3,642	\$8,238,805	0.6%
359	Level II Injections	0.87	153,681	\$7,947,938	0.6%
81	Non-Coronary Angioplasty or Atherectomy	32.75	3,577	\$7,143,148	0.5%
108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	423.31	297	\$7,033,325	0.5%
828	Gemcitabine HCL	1.86	65,666	\$6,942,982	0.5%
322	Brief Individual Psychotherapy	1.29	83,080	\$6,892,256	0.5%
237	Level III Posterior Segment Eye Procedures	34.53	3,100	\$6,863,450	0.5%
303	Treatment Device Construction	2.87	38,448	\$6,851,404	0.5%
823	Docetaxel	5.49	21,746	\$6,799,671	0.5%



<i>Provider</i> Component	<i>Skilled Nursing</i>
Federal Rate	Federal Rate Per Diem
Rate Year	Oct 1– Sept 30
Area Salary Adjustment / Labor Share	Wage Index @ 75.8%
Urban/ Rural Adjustment	Urban and Rural Rates
Medical Education	None
Disproportion- ate Volume of Poor Patients	None
Intensity of Services	RUGS – Resource Utilization Groups
Excessive Costs	None
Partial Treatment	None

Skilled Nursing Facility (SNF) PPS



SNF PPS – The Core Issues

- **Per Diem rates are comprised of urban and rural rates for the following components:**

– Nursing Case Mix	Urban \$142.04	Rural \$135.70
– Therapy Case Mix	Urban \$106.99	Rural \$123.37
– Therapy non-case mix	Urban \$14.09	Rural \$15.05
– Non-case mix	Urban \$72.49	Rural \$73.83

Capital included in the rates.
- **The wage index is based on the hospital inpatient wage index without reclasses or rural floor:**
 - Applied to 75.839% of the Conversion Factor.
- **Payment groups are RUGs – Resource Utilization Groups.**
 - For 2006 increased from 44 to 53 RUGs.
 - RUG classification based on the Minimum Data Set (MDS) patient assessment score.



Example - Per Diem RUG Payment for Skilled Nursing Facility PPS Based on 2007 Final Rule

	Albany SNF			
	Nursing	Therapy	or Non-Case Mix Therapy	Non-Case Mix
Per Diem Rate	\$142.04	\$106.99	\$14.09	\$72.49
Labor Share	75.84%	75.84%	75.84%	75.84%
Labor Share of Rate	\$107.72	\$81.14	\$10.69	\$54.98
Wage Index	0.8720	0.8720	0.8720	0.8720
Adjusted Labor Share	\$93.93	\$70.75	\$9.32	\$47.94
Non Labor Share	\$34.32	\$25.85	\$3.40	\$17.51
Wage-Adjusted Rate	\$128.25	\$96.60	\$12.72	\$65.45
 Resource Utilization Group: RVX - Rehabilitation Very High Plus Extensive Services				
RVX Weight	1.54	1.41		
RVX Payment	\$197.51	\$136.21		\$65.45
Total	\$399.17			



SNF PPS – Other Critical Issues¹¹

- **Medical education / disproportionate volume of poor patients / cost outliers: no payments.**
- **128% add-on for patients with AIDS.**
- **RUG category changes during the course of patient stay based on assessments:**
 - **Day 5 to set RUG for Days 0 – 14**
 - **Day 14 to set RUG for Days 15 – 30**
 - **Day 30 to set RUG for Days 31 - 60**
 - **Day 60 to set RUG for Days 61 – 90**
 - **Day 90 to set RUG for Days 91 – 100**
- **Medicare will pay only the SNF for routine service, capital-related, and ancillary costs provided to patients under the plan of care.**
 - **If another provider renders such a service, Medicare will not pay the provider for that service.**
 - **Medicare specifies services that are not part of the bundled SNF service, for which it will pay other providers directly.**



Table 6: Skilled Nursing Facility RUGs Utilization in 2005

Sample Hospital

RUGs III Category	Description	Nursing Weight	Therapy Weight	Days	% of Total Days
RUC	Rehabilitation Ultra High - C	1.3	2.25	0	0.0%
RUB	Rehabilitation Ultra High - B	0.95	2.25	12	1.6%
RUA	Rehabilitation Ultra High - A	0.78	2.25	25	3.3%
RVC	Rehabilitation Very Low - C	1.13	1.41	0	0.0%
RVB	Rehabilitation Very Low - B	1.04	1.41	35	4.6%
RVA	Rehabilitation Very Low - A	0.81	1.41	0	0.0%
RHC	Rehabilitation High - C	1.26	0.94	45	6.0%
RHB	Rehabilitation High - B	1.06	0.94	0	0.0%
RHA	Rehabilitation High - A	0.87	0.94	23	3.1%
RMC	Rehabilitation Medium - C	1.35	0.77	0	0.0%
RMB	Rehabilitation Medium - B	1.09	0.77	0	0.0%
RMA	Rehabilitation Medium - A	0.96	0.77	56	7.4%
RLB	Rehabilitation Low - B	1.11	0.43	0	0.0%
RLA	Rehabilitation Low - A	0.8	0.43	80	10.6%
SE3	Extensive Services - 3	1.7	0	0	0.0%
SE2	Extensive Services - 2	1.39	0	34	4.5%
SE1	Extensive Services - 1	1.17	0	0	0.0%
SSC	Special Care - C	1.13	0	0	0.0%
SSB	Special Care - B	1.05	0	0	0.0%
SSA	Special Care - A	1.01	0	60	8.0%
CC2	Clinically Complex - 2	1.12	0	0	0.0%
CC1	Clinically Complex - 1	0.99	0	0	0.0%
CB2	Clinically Complex - 2	0.91	0	45	6.0%
CB1	Clinically Complex - 1	0.84	0	0	0.0%
CA2	Clinically Complex - 2	0.83	0	0	0.0%
CA1	Clinically Complex - 1	0.75	0	78	10.4%
IB2	Impaired Cognition - 2	0.69	0	0	0.0%
IB1	Impaired Cognition - 1	0.67	0	45	6.0%
IA2	Impaired Cognition - 2	0.57	0	0	0.0%
IA1	Impaired Cognition - 1	0.53	0	0	0.0%
BB2	Behavior Only - 2	0.68	0	90	12.0%
BB1	Behavior Only - 1	0.65	0	0	0.0%
BA2	Behavior Only - 2	0.56	0	0	0.0%
BA1	Behavior Only - 1	0.48	0	0	0.0%
PE2	Physical Function Reduced - 2	0.79	0	45	6.0%
PE1	Physical Function Reduced - 1	0.77	0	0	0.0%
PD2	Physical Function Reduced - 2	0.72	0	0	0.0%
PD1	Physical Function Reduced - 1	0.7	0	56	7.4%
PC2	Physical Function Reduced - 2	0.65	0	0	0.0%
PC1	Physical Function Reduced - 1	0.64	0	0	0.0%
PB2	Physical Function Reduced - 2	0.51	0	24	3.2%
PB1	Physical Function Reduced - 1	0.5	0	0	0.0%
PA2	Physical Function Reduced - 2	0.49	0	0	0.0%
PA1	Physical Function Reduced - 1	0.46	0	0	0.0%
Default Rate	Default Rate			0	0.0%
Total				753	



<i>Provider</i> Component	<i>Home Health</i>
Federal Rate	National 60 Day Episode Rate
Rate Year	Jan 1– Dec 30
Area Salary Adjustment / Labor Share	Wage Index @ 76.8%
Urban/ Rural Adjustment	None
Medical Education	None
Disproportionate Volume of Poor Patients	None
Intensity of Services	HHRGs – Home Health Resource Groups
Excessive Costs	Cost Outliers & Significant Change
Partial Treatment	Partial Episodes/Low Utilization

Home Health PPS



Home Health PPS – The Core Issues

- **The federal rate is called the national 60-day episode of care rate:**
 - 2007 rate: \$2,339.00 per episode.
 - Capital is included in the rate.
- **The wage index is based on the hospital inpatient wage index without reclasses or rural floor:**
 - Applied to 76.775% of the per episode rate.
- **Payment groups are HHRGs – Home Health Resource Groups.**
 - Resource use is measured for: clinical severity, functional status, and service utilization.
 - Based on 4 levels of clinical severity, 5 levels of functional status, and 4 levels of service utilization – resulting in 80 HHRGs.



Home Health PPS – Other Critical Issues

- **No payments for IME or DSH.**
- **Wage index is based on the location of the patient, not the home health agency.**
- **There are three episode adjustments:**
 - **Low utilization**
 - 4 or fewer visits
 - **High cost outliers; and**
 - **Partial episodes**
 - Beneficiary–elected transfer to another home health agency
 - Completion of treatment and readmission within 60 days
 - Significant change in condition resulting in a new HHRG.
- **Home health rates have experienced significant reductions in rates subsequent to the beginning of the PPS in 2001.**
 - **Many agencies have closed since the 1997 BBA and discontinuation of cost-based reimbursement.**



Provider Component	Inpatient Rehabilitation
Federal Rate	Standard Payment Amount (per Discharge)
Rate Year	Oct 1– Sept 30
Area Salary Adjustment / Labor Share	Wage Index @ 75.6%
Urban/ Rural Adjustment	21.3% Rural Add-On
Medical Education	Teaching Adjustment
Disproportionate Volume of Poor Patients	Low Income Patient Adjustment
Intensity of Services	CMGs (Case-Mix Group) with comorbidities
Excessive Costs	Cost Outliers
Partial Treatment	Short Stay CMG

Hospital Inpatient Rehabilitation PPS



Hospital Inpatient Rehabilitation PPS – The Core Issues

- The federal rate is called the standard payment amount (per discharge):
 - 2007 rate: \$12,981 per discharge.
 - Capital is included in the rate.
- The wage index is based on the hospital inpatient wage index without reclasses or rural floor:
 - Applied to 75.612% of the per discharge rate.
- Payment groups are CMGs – Case-Mix Groups.
 - Initial assessment is based on 21 Rehabilitation Impairment Categories (RICs)
 - Further partitions are based on measures of motor and cognitive scores, age, and comorbidities – resulting in 290 CMGs.



Hospital Inpatient Rehabilitation PPS – Other Critical Issues

- **Medical Education:** indirect medical education adjustment implemented for 2006 - based on the ratio of interns and residents to average daily census in the rehabilitation hospital/unit.
- **Cost Outliers:** - same concept as inpatient operating cost outliers.
- **Low Income Percentage Adjustment:**
 - Based on the rehabilitation hospital/unit's share of Medicaid and Medicare SSI patients.
- **21.3% adjustment for hospitals located in a rural area:**
 - Transitional adjustment for hospitals that have been redesignated from rural to urban.



Hospital Inpatient Rehabilitation PPS – Other Critical Issues continued

- **Partial payments for patients transferred to:**
 - **Another rehabilitation facility, long-term care hospital, an inpatient hospital, or nursing home; and**
 - **The length of stay is less than the average length of stay for the CMG.**
- **Interrupted stays**
 - **Discharges and returns within 3 days are treated as the same admission.**



Provider Component	Inpatient Psychiatric
Federal Rate	Per Diem Base Rate
Rate Year	Jul 1– June 30
Area Salary Adjustment / Labor Share	Wage Index @ 75.7%
Urban/ Rural Adjustment	17 % Rural Add-On
Medical Education	Teaching Adjustment
Disproportionate Volume of Poor Patients	None
Intensity of Services	DRGs with day weights and comorbidities
Excessive Costs	None
Partial Treatment	None

Hospital Inpatient Psychiatric PPS



Hospital Inpatient Psychiatric PPS – The Core Issues

- **The federal rate is called the base rate (per diem):**
 - Current 2007 rate: \$595.09 per day.
 - Rural hospitals receive an additional 17%.
- **The wage index is based on the hospital inpatient wage index without reclasses or rural floor:**
 - Applied to 75.665% of the per diem rate.
- **Payment groups are DRGs.**
 - 15 Inpatient Psychiatric DRGs.



Hospital Inpatient Psychiatric PPS – Other Critical Issues

- **Teaching adjustment:**
 - Based on the ratio of interns and residents to average daily census in the psychiatric hospital/unit.
- **Cost Outliers** - same concept as inpatient operating cost outliers.
- **No DSH Adjustment**
- **Patient Level Adjustment Factors:**
 - Day weights:
 - Day 1 at 1.31, Day 2 at 1.12, Day 3 at 1.08, etc. down to .99 at Day 11 and higher.
 - Age Adjustment
 - Adjustment for comorbidities



Provider Component	Long Term Care Hospitals
Federal Rate	Federal Rate
Rate Year	Jul 1– June 30
Area Salary Adjustment / Labor Share	Wage Index @ 75.7%
Urban/ Rural Adjustment	None
Medical Education	None
Disproportionate Volume of Poor Patients	None
Intensity of Services	LTC-DRGs
Excessive Costs	Cost Outliers
Partial Treatment	Short Stay Outliers

Long Term Care Hospital PPS



Long Term Care Hospital PPS – The Core Issues

- **The federal rate is called the federal rate:**
 - **Current 2007 rate: \$38,086.04**
- **The wage index is based on the hospital inpatient wage index without reclasses or rural floor:**
 - **Applied to 75.665% of the federal rate.**
- **Payment groups are DRGs.**



Long Term Care Hospital PPS – Other Critical Issues

- **No Teaching Adjustment**
- **No DSH Adjustment**
- **Cost Outliers** - same concept as inpatient operating cost outliers.
- **Short Stay Outliers:** Complex payment method based on the lower of:
 - 120% of LTC DRG per diem x case length of stay
 - 100% of case costs
 - Full LTC PPS payment
 - Blend of IPPS DRG per diem payment and 120% of LTC DRG per diem x case length of stay



Cost-Based Reimbursement

- **Hospitals - Direct Medical Education**
- **Critical Access Hospitals**
- **Rural Health Clinics**
- **Sole Community Hospitals**
 - Higher of PPS or trended base year costs



Direct Medical Education



Direct Medical Education

- **Per Resident payment amount intended to reimburse for:**
 - Intern and resident salaries, supervising physician salaries, and associated overhead costs
 - 2 amounts: primary care and all other
- **Based on hospital-specific base-year costs trended by the consumer price index for urban areas (CPI-U)**
- **Upper and lower limits to the wage adjusted national Per Resident amount:**
 - Estimated national 2006 per resident amount = \$88,876
 - Wage adjusted by the physician Geographic Practice Cost Index (GPCI).
 - Upper Limit = 140% of wage-adjusted value
 - Lower limit = 85% of wage adjusted value

Hospital per resident amounts below the lower limit receive the lower limit. Hospital per resident amounts above the upper limit receive no annual update.



Direct Medical Education

- **The final per resident amounts are applied to the hospital's resident counts:**
 - Multiplied by the hospital's Medicare share of patient days.
- **Allowable resident counts are limited to 1996 base year counts:**
 - Special rules to phase-in reductions and new programs.

The 2005 Final Inpatient PPS Rule implemented the MMA mandate to reduce the 1996 base year resident levels for hospitals that have not utilized their full resident allowance. Unused resident slots were redistributed to hospitals that requested and received cap increases.



Sole Community Hospitals



Sole Community Hospitals - Eligibility

- **For urban hospitals - must be located more than 35 miles from other hospitals.**
- **For rural hospitals – several alternative criteria based on distance, patient share, travel time, and weather conditions.**



Sole Community Hospitals - Reimbursement

- **Paid higher of trended 1982, 1987, 1996 base year costs (Hospital Specific Rate) or federal inpatient PPS operating amount.**
 - No special treatment for other services.
 - Annual update factor slightly different from inpatient PPS because wage index budget neutrality adjustment not applied to SCHs as of 2006.
- **Eligible for increase in payment amount based on volume decreases.**
- **Receive a 7.1% add-on to Outpatient PPS payments.**



Medicare Dependent Hospitals



Medicare Dependent Hospitals - Eligibility

- **Hospital is located in a rural area;**
- **Hospital has 100 or fewer beds;**
- **At least 60 percent of the hospital's acute inpatient days or discharges are attributable to Medicare Part A beneficiaries; and**
- **The hospital is not a Sole Community Provider.**





Medicare Dependent Hospitals³⁵ - Reimbursement

- **Paid the higher of the federal rate or a blend of the federal rate and the Hospital Specific Rate for inpatient services.**
 - No special treatment for other services.
 - Hospital Specific Rate blend percentage was increased from 50% to 75% by the Deficit Reduction Act (DRA).
 - DRA also exempted Medicare Dependent Hospitals from the rural cap on DSH payments.
- **Eligible for increased payment amount based on volume decreases.**
- **Receive a transitional, hold-harmless adjustment to Outpatient PPS payments.**



Critical Access Hospitals (CAHs)



Critical Access Hospitals - Eligibility

- **Located in a federal or state defined rural area**
- **More than 35 road miles from a similar hospital (15 miles in certain conditions)**
- **Provides 24 hour emergency services**
- **No more than 25 beds**
- **Annual average length-of-stay of no more than 96 hours**



Critical Access Hospitals - Reimbursement

- **Entirely based on 101% of allowable costs, with no limits, for:**
 - Inpatient Acute and Swing Bed
 - Outpatient PPS and Therapies
 - Laboratory services for their own patients
 - Ambulance services absent another near-by service
- **All Other Services based on PPS or Fee Schedule:**
 - Home Health
 - Skilled Nursing Facility



Rural Health Clinics



Rural Health Clinics – Eligibility

- **Entity in an area currently designated as rural, and currently:**
 - **Medically underserved area (MUA),**
 - **Health professional shortage area, or**
 - **Governor-designated shortage area**
- **Must have a nurse practitioner, PA, or nurse-midwife available at least 50% of clinic hours.**
- **Must perform annual Quality Assessment Program.**
- **Must not be co-mingled with another practice.**



Rural Health Clinics - Reimbursement

- **Rural Hospital under 50 beds**
 - 100% of allowable costs
 - Beneficiary co-pay applies
 - Vaccines paid 100% by program, no copayment
- **Hospitals with 50+ beds, or Independent (not provider-based)**
 - Limit on per-visit cost, updated annually
 - Per-visit payment is all-inclusive



Fee Schedule Reimbursement

- **Physicians**
- **Hospital – Outpatient Rehabilitation/
Therapy Services**
 - Uses the Physician Fee Schedule
- **Laboratories**
- **Ambulance Services**



Physicians



Physician Fee Schedule - Reimbursement

- **Similar to a PPS in its determination of the fee for each procedure**
 - Starts with a federal rate called the Conversion Factor: \$35.9848 in 2007, a 5% reduction from the 2006 rate
- **Relative Value Units (RVUs) for 3 components**
 - Work – service intensity
 - Practice Expense (separate facility/non-facility values)
 - Malpractice
- **Geographic Practice Cost Indices (GPCIs) for same 3 components**

Annual updates based on controversial "Sustainable Growth" method linked to changes in Gross Domestic Product Rate.



Example - Payment to Facility-Based Physician Under Physician Fee Schedule

Based on 2007 Final Rule

Office Visit - New patient	CPT/HCPCS 99201
Conversion Factor	\$35.9848
Work RVU	0.45
Work GPCI	1.065 Manhattan
Facility Practice Expense RVU	0.15
Practice Expense GPCI	1.000 (Facility Based)
Malpractice RVUs	0.03
Malpractice GPCI	1.480 Manhattan
Work weight	0.48
Facility Practice Expense weight	0.15
Malpractice weight	0.04
Total weight	0.67
Office Visit - New Patient	\$24.24



Hospital - Outpatient Rehabilitation/Therapy Services



Outpatient Rehabilitation/ Therapy Services

Physical, occupational, and speech therapies under plan of care with regular physician certification of need

- **Paid under physician fee schedule**
 - Cost based until 1999
 - CAHs still paid at cost
- **Annual caps beginning FFY 2004 except when provided in a hospital OPD**
 - PT and SP combined cap = \$1,780
 - OT cap = \$1,780



Laboratory



Clinical Lab Fee Schedule

- **Set payment for each service with locality variations for some services**
- **Payments usually updated each calendar year:**
- **Separate payment for drawing and for travel**
- **CAHs get cost except for services to non-patients**
- **No beneficiary co-pay at this time**



Clinical Lab Fee Schedule

Payment is the lower of:

- **Fee schedule,**
 - **62% of updated base prevailing charge for Sole Community Hospitals**
 - **60% of updated base prevailing charge for others**
- **National limit = 74% of median local fees, or**
- **Charges**



Ambulance Services



Ambulance Fee Schedule

- **Began April 1, 2002 – cost per trip with limit prior**
- **Phased in over 5 years – 100% in Calendar 2007**
- **Weights based on type of service – 8 different types**
- **Payments updated each calendar year.**
 - **Ambulance Increase Factor = 4.3% for CY 2007.**



Ambulance Fee Schedule – MMA Changes

- **Increase for lowest quartile of rural counties**
- **Blend of national and regional fee schedules when region is higher (for ground services only)**
- **Increase for ground services**
 - 1% for urban
 - 2% for rural (add-on for rural ground service miles 1-17 and 51+ expired Jan. 1, 2004)



Other Services

- **End Stage Renal Disease**
- **Hospice**
- **Durable Medical Equipment**



End-Stage Renal Disease (ESRD) Services

Maintenance dialysis treatments for end-stage patients

- **Facility must be approved**
- **Composite rate – prospective and all-inclusive**
 - Higher for hospital based vs. free-standing
 - Geographic adjustment for wages



Hospice

- **Per diem rates for 2007**
 - Routine Home Care: \$130.79
 - Continuous Home Care (Full Rate = 24 hours of care; Hourly Rate = \$31.81): \$763.36
 - Inpatient Respite Care: \$135.30
 - General Inpatient Care: \$581.82
- **Updated by marketbasket**
 - 3.4% for FFY 2007
- **Wage index based on hospital wage data with adjustments**
 - labor share varies by category
- **Overall cap on benefit**



Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

- **Three payment methods**
 - **Fee Schedules** – most common, state specific fee per item
 - **Reasonable Charge** – Parenteral and Enteral Nutrition and certain DME items
 - **Average Wholesale Price** – immunotherapy, bronchodilator, and other drugs

