

CALIFORNIA HEALTH ADVOCATES

Part A Payments

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Trainer

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Objectives for Training

- ❖ Purpose of today's training is to provide an overview of how benefits in Part A of Medicare are paid.
- ❖ Will also present any programs/policies/rules that will increase or decrease a payment.
- ❖ Will review the 2015 Beneficiary responsibility for Part A payments.

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BACKGROUND INFORMATION

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Historical Perspective on Medicare Payments

- Prior to passage of the 1965 law establishing the Medicare program, approximately 50% of seniors did not have hospital insurance.
- When Medicare coverage began on July 1, 1966, it covered more than 19 million beneficiaries.

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- When the law was passed, it was modeled on the private sector insurance plans.
- Hospitals nominated an intermediary that would process their claims.
- Payment methods for facilities (including hospitals, skilled nursing facilities, home health agencies) was based on reasonable costs.

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Reasonable Costs


- Until 1983, providers were paid the lower of their reasonable costs or their customary charges for services provided to Medicare beneficiaries.
- At the close of a provider's fiscal year, the provider submits a cost report to the intermediary showing all cost incurred and the portion allocated to the Medicare program.

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- Reasonable costs were defined by law that stated it was:
 - “the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services”


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Why this Approach?

- Made sure Medicare beneficiaries would have access to care like privately insured patients.
- Allowed faster implementation of the new program partly because the model looked familiar to providers, insurance companies and the beneficiaries.


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Concerns

- Over time, Congress became concerned that while reimbursing reasonable costs, the system did not encourage providers to provide services efficiently or otherwise limit their costs.
- Original payment methods turned out to be inflationary which resulted in significant changes to how Medicare pays claims.


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Part A Coverage - 1965

- Inpatient hospital services, including inpatient psychiatric hospital services and inpatient tuberculosis hospital services
- Post-hospital extended care services
- Post-hospital home health services
- Outpatient hospital diagnostic services


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Part A Coverage Today

- Inpatient Hospitals
 - Psychiatric Hospitals
 - Rehabilitation Hospitals
- Skilled Nursing Facility
- Home Health Benefits
- Hospice
- Blood

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INPATIENT HOSPITAL COVERAGE

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Inpatient Hospital Coverage

42 C.F.R. 409.10 – included services:

- (1) Bed and board.
- (2) Nursing services and other related services.
- (3) Use of hospital or CAH facilities.
- (4) Medical social services.
- (5) Drugs, biologicals, supplies, appliances, and equipment.

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Services Covered, cont.

- (6) Certain other diagnostic or therapeutic services.
- (7) Medical or surgical services provided by certain interns or residents-in-training.
- (8) Transportation services, including transport by ambulance.

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Services Excluded

- (1) Posthospital SNF care, as described in §409.20, furnished by a hospital or a critical access hospital that has a swing-bed approval.
- (2) Nursing facility services, described in §440.155 of this chapter, that may be furnished as a Medicaid service under title XIX of the Act in a swing-bed hospital that has an approval to furnish nursing facility services.

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Services Excluded, cont.

- (3) Physician services that meet the requirements of §415.102(a) of this chapter for payment on a fee schedule basis.
- (4) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

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Services Excluded, cont.

- (5) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.
- (6) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

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Services Excluded, cont.

- (7) Qualified psychologist services, as defined in section 1861(ii) of the Act.
- (8) Services of an anesthetist, as defined in §410.69

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Beneficiary Costs - currently

- For in-patient hospital stays, the beneficiary is subject to a deductible and copay amounts, per benefit period.

Determining the Deductible

The law requires the Secretary to adjust the inpatient hospital deductible each year to reflect changes in the average cost of hospital care. The inpatient hospital deductible is increased each year by about the same percentage as the increase in the average Medicare daily hospital costs.

Refresher for 2015

- Part A Deductible for 2015 is \$1260 (per benefit period)
- Hospital coinsurance for days 61-90 is \$315 (25% of the deductible)
- Hospital coinsurance for days 91-150 (life-time reserve days) is \$630 (50% of the deductible)

Medicare Payments to Hospitals

- From 1966 to 1983: reasonable cost methodology
- 1983 – an inpatient Prospective Payment System (IPPS) replaced the cost-based payments; it was a pre-determined rate that was paid based on a patient's diagnosis

- Each discharge is assigned to a diagnosis-related group (DRG)
- DRGs group similar clinical conditions and the procedures furnished during the hospital stay to a patient
- Grouping is based on the primary diagnosis and up to 24 secondary diagnoses as well as up to 25 procedures

- Since October 1, 2007, CMS is using a new DRG system called Medicare Severity (MS)-DRGs.
- It was phased in and fully operational as of October 1, 2008.
- System takes into account severity of the illness and the resource consumption in treating the patient.

Levels of Severity for a MS-DRG

- Level of severity is based on the secondary diagnosis code
- Listed from highest to lowest:
 - MCC-Major Complication/Comorbidity
 - CC-Complication/Comorbidity
 - Non-CC – Non-Complication/Comorbidity

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IPPS Per Discharge Payment

- Based on 2 national base payment rates (standardized amounts)
 - One is for operating expenses
 - One is for capital expenses

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Both amounts can be affected by:

- the costs associated with the beneficiary's clinical condition and treatment relative to costs of average Medicare case, as well as,
- Market conditions in the hospital's location relative to national conditions.

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Other Adjustments to IPPS DRG Payments

- Over time, various other programs policies and laws have been established that will increase or decrease a specific DRG payment for a specific hospital and/or a specific discharge.

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Outlier Payments

Outlier Payments are for extremely costly cases.

- To qualify for an outlier payment, a case must have a dollar amount by which the costs of a case exceed payments in order to qualify for the outlier payments.
- Outliers account for about 5.1% of total hospital payments.

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Graduate Medical Education

Hospitals with an approved **Graduate Medical Education** program, receive additional payments for training residents.

- Also, the operating and capital payments for these teaching hospitals are increased to reflect the higher indirect patient care costs.

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Disproportionate Share Hospital Payments

DSH (Disproportionate Share Hospitals) Payments are:

- Increased rates for hospitals treating a disproportionate share of low-income patients.
- Calculations consider the number of inpatient days for beneficiaries with Medicare & Medicaid vs those with only Medicaid

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New Technologies

- Additional payments for treating patients with **certain approved technologies** that are new and costly and provide improved care.

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Bad Debts

- Additional payments for **bad debts** (ex. Beneficiaries who do not pay their deductible after being billed by the hospital).
- If approved, a hospital receives a percentage of the bad debt.

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Transfers

- Reduced payments when a beneficiary has a short hospital stay and transfers to another hospital.

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Hospital Value-Based Purchasing

- Beginning October 1, 2012, there are adjustments under the Hospital **Value-Based Purchasing (VBP)** Program.
- Payments under VBP are based on performance for certain quality measures.

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Readmissions

- Beginning October 1, 2012, reduction of IPPS for hospitals with excess readmissions.
- Based on a comparison of a hospital's readmission performance compared to national average for:
 - Acute myocardial infarction
 - Heart failure
 - Pneumonia

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Hospital Acquired Condition Reduction Program (HAC)

- First introduced in the Deficit Reduction Act of 2005
- Saves Medicare approximately \$30 million annually
- Enhanced in 2010 with passage of the Affordable Care Act

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HAC Savings

- Achieved by not paying additional Medicare funds for certain reasonably preventable conditions acquired after the beneficiary is admitted to the hospital.
- The HAC Reduction Program builds on the Administration's efforts to achieve better patient outcomes while slowing health care cost growth.

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Based on the Hospital's performance:

- Hospitals receive a score of 1-10, based on Total HAC score
- 10 is the worst score,
- Scores are now on Hospital Compare

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- Beginning in FY 2015, hospitals with the worst scores will have their reimbursement reduced by 1%.
- Approximately 724 hospitals are seeing the reduction this year.
- Effective for any discharge since October 1, 2014.

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Recovery Auditor Contractors (RACs)

Mission:

- To detect and correct past improper payments so that CMS can implement actions that will prevent future improper payments.

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Recovery Audit Legislation

- Medicare Modernization Act, Section 306
 - Required the three year Recovery Audit demonstration
- Tax Relief and Healthcare Act of 2006, Section 302
 - Required a permanent and nationwide Recovery Audit program by no later than 2010

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Recovery Audit Review Process

- Recovery Auditors review claims on a post-payment basis.
- Recovery Auditors use the same Medicare policies.
- Look back 3 years at claims.
- Must have a staff consisting of nurses, therapists, certified coders and a physician.

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Three types of review:

- Automated (no medical record needed)
- Semi-Automated (claims review using data and potential human review of a medical record or other documentation)
- Complex (medical record required)

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Claim Type	Correction by Provider Types FY 2013		
	Overpayments Collected	Underpayments Restored	Total Incorrect Payments
Inpatient	\$3,437,554,670	\$86,149,338	\$3,523,704,008
SNF	\$1,840,735	\$19,567	\$1,860,302
Home Health (A & B)	\$6,386,724	\$4,037,775	\$10,424,498
Hospice	\$34,858	\$0	\$34,858
Total Payments (A)	\$3,445,816,987	\$90,206,680	\$3,536,023,666
Total Payments (All A & B)	\$3,650,914,625	\$102,408,504	\$3,753,323,129

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SKILLED NURSING FACILITY (SNF) COVERAGE

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Skilled Nursing Facility (SNF) Coverage

42 C.F.R 409.20, services include:

- 1) Nursing care provided by or under the supervision of a registered professional nurse.
- 2) Bed and board in connection with the furnishing of that nursing care.

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- (3) Physical therapy, occupational therapy, and speech-language pathology services.
- (4) Medical social services.
- (5) Drugs, biologicals, supplies, appliances, and equipment.

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- (6) Services furnished by a hospital with which the SNF has a transfer agreement in effect under §483.75(n) of this chapter.
- (7) Other services that are generally provided by (or under arrangements made by) SNFs.

- Excluded Services include:
 - (1) *Services that are not considered inpatient hospital services.*
 - (2) *Services not generally provided by (or under arrangements made by) SNFs.*

Beneficiary Costs - currently

- For skilled nursing facility stays, the beneficiary is subject to copay amounts, per benefit period.

Refresher for 2015

- Medicare covers up to 100 days of SNF care per each benefit period.
- Medicare pays 100% of allowed costs for first 20 days.
- Beneficiary pays \$157.50 (12.5% of deductible) for days 21 – 100 in each benefit period.

Current Payment Method

- The Skilled Nursing Facility Prospective Payment System (SNF PPS) was implemented on July 1, 1998.
- It is a comprehensive per diem amount under a PPS.
- The SNF PPS per diem represents payment for all costs of furnishing Part A SNF services.
- The rates include a Part B add-on to account for what had traditionally been billed separately under Part B.

SNF PPS Rates

- Two elements for a SNF PPS per diem amount affect the standardized urban and rural Federal per diem rates.
 - Wage Adjustments – based on the geographical location
 - Patient specific information (patient case-mix)

Patient Case-Mix

- This is the relative resource intensity that is typically associated with each patient's clinical condition.
- Obtained by using a standard assessment process.
- Currently, can classify patients into one of 66 different Resource Utilization Groups or RUGs.

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Consolidated Billing

- This is similar to hospital bundling which requires billing on the Part A bill all Medicare-covered services received, with the exception of a finite list of Part B services that is billed separately by an outside entity.
- The SNF must bill for all PT, OT and SLP services.

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Therapy Billing

- Prior to the change, a SNF could:
 - Provide services directly
 - Provide through a transfer agreement with a hospital
 - Provide under arrangement with an independent therapist
- Further, the SNF could bill directly for services, or allow an outside supplier to bill directly.

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Problems before CB

- Potential duplicate billing (by SNF and Part B outside provider)
- Increased beneficiary liability for Part B deductible and coinsurance
- Quality of care affected if responsibility of patient care dispersed among several providers.

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HOME HEALTH COVERAGE

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Home Health Coverage

- **42 C.F.R. 409.44**, Qualifying Services for HHA Coverage
 - (1) *Skilled nursing care*
 - (2) *Physical therapy,*
 - (3) *Speech-language pathology services,*
 - (4) *Occupational therapy* (conditions required to be met)*


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- **42 C.F.R. 409.45**, Dependent Services
 - (1) *Home health aide services*
 - (2) *Medical social services*
 - (3) *Occupational therapy*
 - (4) *Durable medical equipment.*
 - (5) *Medical supplies*
 - (6) *Intern and resident services.*


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Excluded Services


- *Drugs and biologicals*
- *Transportation*
- *Services that would not be covered as inpatient services*
- *Housekeeping services*
- *Services covered under the End Stage Renal Disease (ESRD) program*

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- *Prosthetic devices.*
- *Medical social services provided to family members*


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Beneficiary Costs

- Coinsurance (20%) for any HHA supplied DME.
- No other costs for the beneficiary.


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Current Payment Method


- The Home Health Prospective Payment System (HH PPS) was implemented on October 1, 2000.
- HH PPS episodic rate includes payment for all services and supplies, with the exception of certain covered osteoporosis drugs and DME.
- The HHA must provide all covered services (except DME) either directly or under arrangement.

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- A unit of payment to the HHA is for a 60-day episode of care.
- Two payments are made for each episode – one at the start when a Request for Anticipated Payment (RAP) is filed and one at the end when the claim is filed.
- There is no limit to the number of episodes of care – if medically needed.

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- The HH PPS is adjusted based on characteristics of the patient and treatment/care needs.
- Information for these adjustments are based on data elements from the Outcome and Assessment Information Set (OASIS) completed by the intake nurse/therapist.

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- Completion of the current OASIS will place the patient in one of 153 possible Home Health Resource Groups.
- The OASIS is completed for each episode of care (each 60 day period).

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- Second component of the HH PPS reflects the labor portion.
- CMS adjusts this portion based on the geographic area in which the patient receives HH services.


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Outlier Payments

- Outlier payments can be made to HHAs for episodes with unusually large costs due to patient HH care needs.
- Outlier payments are made for episodes when the estimated costs exceed a set threshold amount.
- Law requires that total outlier payments do not account for more than 5% of total HHA payments for a year.


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Additional Adjustments

- Low-Utilization Payment Adjustment
- Partial Episode Payment Adjustment
- Per the ACA, for episodes ending on or after April 1, 2010 and before January 1, 2016, rural areas receive a 3% add-on for certain conditions.

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Quality Reports

- Since CY 2007, HHAs payments are reduced by 2% if the HHA does not report the required quality data.

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HOSPICE COVERAGE

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Historical Information

- 1979: Health Care Financing Administration (aka CMS) created a demonstration project for 26 hospices nationally.
- 1982: Medicare Hospice benefit passed by Congress; sunsets in 1986.
- 1986: Benefit is made permanent.

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Hospice Coverage

42 C.F.R. 418.202 Covered Services:

- (1) Nursing care
- (2) Medical Social Services
- (3) Physician Services
- (4) Counseling Services for patient and family/caregivers
- (5) Short-term inpatient care

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- (6) *Medical appliances and supplies, including drugs and biologicals*
- (7) *Home health or hospice aide services*
- (8) Physical therapy, occupational therapy and speech-language pathology services

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(9) Effective April 1, 1998, any other service that is specified in the patient's plan of care as reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions and for which payment may otherwise be made under Medicare.

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Beneficiary Costs

- *Drugs and biologicals* - for each prescription approximates 5 percent of the cost of the drug or biological to the hospice not to exceed \$5 per prescription.
- *Respite care* - the amount of coinsurance for each respite care day is equal to 5 percent of the payment made by CMS for a respite care day.

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Current Payment Method

- a) CMS establishes payment amounts for specific categories of covered hospice care.
- (b) CMS pays rates for each day a beneficiary is enrolled in hospice.
- (c) Payment amounts are determined within each of the 4 categories.

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How Rates Are Determined

- o Each Hospice payment rate is comprised of 2 components:
 - Labor Share
 - Non-labor share
- o Each Hospice payment rate is adjusted to account for differences in wage rates among markets.

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Levels of Care in Hospice

- 1) **Routine home care day**. A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous care
 - o For FY 2015, the routine home care day rate is \$156.06 (before wage adjustment for the hospice).

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- (2) **Continuous home care day**. A continuous home care day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home.
 - o For FY2015 the continuous home care day rate is \$910.78 (before wage adjustment for the hospice).

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- (3) **Inpatient respite care day**. An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite.
 - o For FY2015 the inpatient respite care day rate is \$161.42 (before wage adjustment for the hospice).

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- (4) **General inpatient care day**. A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.
 - o For FY2015 the general inpatient care day rate is \$696.19 (before wage adjustment for the hospice).

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Caps on Hospice Payments

- Two Caps exist that affect total yearly payments to a hospice.

Inpatient Cap: Number of inpatient care furnished by the hospice cannot be more than 20% of total patient care days.

Aggregate Cap: Total amount of yearly Medicare payments cannot exceed a yearly set amount times the number of Medicare patients served.

FYI: Hospice aggregate cap amount for cap year ending October 31, 2013 was \$26,157.60.

Reduction in Payments

- Each payment rate is reduced by 2 percentage points for any Hospice that does not comply with submission of data for required quality measures.
- Previous payment rates quoted for FY 2015 did not reflect this reduction.

Quality Measures Currently (FY2015) being Reported

- Patients treated with an opioid who are given a bowel regimen
- Pain screening
- Pain assessment
- Dyspnea treatment
- Dyspnea screening
- Treatment preferences
- Beliefs/values addressed (if desired)

BLOOD DEDUCTIBLE

Blood Deductible (Part A)

Medicare covers all costs once deductible is met.

42 C.F.R. 409.87

- The beneficiary is responsible for the first 3 units of whole blood or packed red cells. He or she has the option of paying the hospital's or CAH's charges for the blood or packed red cells or arranging for it to be replaced.

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(1) As used in this section, packed red cells means the red blood cells that remain after plasma is separated from whole blood.

(2) A unit of packed red cells is treated as the equivalent of a unit of whole blood.

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(3) Medicare does not pay for the first 3 units of whole blood or units of packed red cells that a beneficiary receives, during a calendar year, as an inpatient of a hospital or CAH or SNF, or on an outpatient basis under Medicare Part B.

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(4) The deductible does not apply to other blood components such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin, or to the cost of processing, storing, and administering blood.

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(5) The blood deductible is in addition to the inpatient hospital deductible and daily coinsurance.

(6) The Part A blood deductible is reduced to the extent that the Part B blood deductible has been applied.

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Summary of Dates

- IPPS – established in 1983.
- SNF consolidated billing and PPS per diem – 1997
- HH PPS – payments began Oct 1, 2000
- Hospice – created benefit - 1982

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It's **QUESTION TIME!!**


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RESOURCES

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Medicare Learning Network Fact Sheets

- Acute Care Inpatient Hospital Prospective Payment System, ICN 006815 April 2013

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymentSystemFactSheet.pdf>


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- Skilled Nursing Facility Prospective Payment System, ICN 006821, September 2014
- <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/snfprospectivepaymentfactsheet.pdf>


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- Home Health Prospective Payment System, ICN 006816, December 2012
- <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HomeHealthProspectivePaymentFactSheet.pdf>

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- Hospice Payment System, ICN 006817, December 2013
- <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospicepaymentfactsheet.pdf>

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Reference Material Used

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- Health Care Financing Review, Fall 2000, *Medicare: 35 Years of Service*
- National Hospice and Palliative Care Organization – History of Hospice Care


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