

CRS Report for Congress

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Medicare Payment Policies

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Medicare Payment Policies

Summary

Medicare is the nation's health insurance program for the aged, disabled, and persons with End Stage Renal Disease (ESRD). Part A of the program, the Hospital Insurance program, covers hospital services, post-hospital services provided in skilled nursing facilities and by home health care agencies, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of complementary medical services including physician, laboratory, and outpatient hospital services, and durable medical equipment. Part C provides managed care options for beneficiaries who are enrolled in both Parts A and B. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added Part D to Medicare, a new prescription drug benefit that began on January 1, 2006.

Medicare has established specific rules for payment of covered benefits under Parts A, B, and C. Some, such as physician services and durable medical equipment, are based on fee schedules. Most services, including those provided in inpatient hospitals, inpatient rehabilitation facilities, long-term care hospitals, psychiatric hospitals and skilled nursing facilities, are paid under different prospective payment systems (PPSs). In general, the program provides for annual updates to these payment amounts. The program also has rules regarding the amount of cost-sharing, if any, which beneficiaries can be billed in excess of Medicare's recognized payment levels.

Medicare payment policies and potential modifications to these policies are of continuing interest to Congress. The Medicare program has been a major focus of deficit reduction legislation since 1980. With a few exceptions, reductions in program spending have been achieved largely through reductions in payments to providers, primarily hospitals and physicians. The Balanced Budget Act of 1997 (P.L. 105-33, BBA 97) modified some payment policies in place at that time, including changing underlying payment methodologies and updates to payment amounts. Subsequently, Congress passed the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (P.L. 106-113, BBRA) and the Benefits Improvement and Protection Act of 2000 (P.L. 106-554, BIPA 2000), both of which contained funding increases to mitigate the impact of some BBA 97 provisions on providers. MMA, too, modified payment methods and established payment increases for some providers. Most recently, further modifications were made to Medicare payments in the Deficit Reduction Act of 2005 (P.L. 109-171, DRA).

This report provides an overview of Medicare payment rules by type of service, outlining current payment policies and providing a summary of the basic rules for updating the payment amounts. The report also includes the most recent update for each type of service. At the back of the report is a listing of CRS reports providing more in-depth discussions of provider payment issues. This report will be updated for any legislative activity.

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Medicare Payment Policies

Introduction

Medicare is the nation's health insurance program for the aged, disabled, and persons with End Stage Renal Disease (ESRD). Part A of the program, the Hospital Insurance program, covers hospital services, up to 100 days of post-hospital skilled nursing facility services, post-institutional home health visits, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of medical services including physician services, laboratory services, durable medical equipment, and outpatient hospital services. Part B also covers some home health visits. Part C provides managed care options for beneficiaries who are enrolled in both Parts A and B. Part D provides outpatient prescription drug coverage.

Medicare Payment Principles

In general, the total payment received by a provider for covered services provided to a Medicare beneficiary is composed of two parts: a program payment amount from Medicare plus any beneficiary cost-sharing amount that is required.¹ (The required beneficiary out-of-pocket payment may be paid by other insurance if any.) Medicare has established specific rules governing its program payments for all covered services as well as beneficiary cost-sharing as described below.

Medicare Payment Rules. Medicare has established specific rules governing payment for covered services under Parts A, B, and C.² For example, the program pays for most acute inpatient and outpatient hospital services, skilled nursing facility services, and home health care under a prospective payment system (PPS) established for the particular service; under PPS, a predetermined rate is paid for each unit of service such as a hospital discharge or payment classification group. Payment for physician services, clinical laboratory services, and durable medical equipment are made on the basis of fee schedules. Certain other services are paid on the basis of reasonable costs or reasonable charges. In general, the program provides for annual updates of the payment amounts to reflect inflation and other factors. In some cases, these updates are linked to the consumer price index for all urban

¹ Not all services require cost-sharing from a beneficiary. For instance, clinical laboratory services and home health services do not require payments from a beneficiary or a beneficiary's insurance, such as Medicare supplemental insurance (Medigap) or employer sponsored retiree health insurance.

² Outpatient prescription drugs covered under Part D are not subject to Medicare payment rules. Prices are determined through negotiation between prescription drug plans (PDPs), or Medicare Advantage PDPs, and drug manufacturers. The Secretary of Health and Human Services is statutorily prohibited from intervening in Part D drug price negotiations.

consumers (CPI-U) or to a provider-specific market basket (MB) index which measures the change in the price of goods and services purchased by the provider to produce a unit of output.

Beneficiary Out-of-Pocket Payments. There are two aspects of beneficiary payments to providers: required cost-sharing amounts (either coinsurance or deductibles) and the amounts that beneficiaries may be billed over and above Medicare's recognized payment amounts for certain services. For Part A, coinsurance and deductible amounts are established annually; these payments include deductibles and coinsurance for hospital services, coinsurance for SNFs, no cost sharing for home health services, and nominal cost-sharing for hospice care. For Part B, beneficiaries are generally responsible for a \$124 deductible in 2006, updated annually by the increase in the Part B premium, and a coinsurance payment of 20% of the established Medicare payment amounts. For Part C, cost-sharing is determined by the managed care plans. Through 2005, the total of premiums and cost-sharing amounts charged to a beneficiary by a managed care organization cannot exceed actuarially-determined levels of cost-sharing for Parts A and B of traditional Medicare. Beginning in 2006, this restriction will be lifted for Part C, but the Secretary will have expanded authority to negotiate or reject a bid from a managed care organization for the coverage of required Medicare benefits and supplemental benefits. Part D cost-sharing includes a deductible, co-payments, and catastrophic limits on out-of-pocket spending.³

For most services, there are rules on amounts beneficiaries may be billed over and above Medicare's recognized payment amounts. Under Part A, providers agree to accept Medicare's payment as payment in full and cannot bill beneficiaries amounts in excess of the coinsurance and deductibles. Under Part B, most providers and practitioners are subject to limits on amounts they can bill beneficiaries for covered services. For example, physicians and some other practitioners may choose whether or not to accept **assignment** on a claim. When a physician accepts assignment, Medicare pays the physician 80% of the approved fee schedule amount. The physician can only bill the beneficiary the 20% coinsurance plus any unmet deductible. When a physician agrees to accept assignment of *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**. Nonparticipating physicians may or may not accept assignment for a given service. If they do not, they may charge beneficiaries more than the fee schedule amount on nonassigned claims; for physicians, these **balance billing** charges are subject to certain limits.

For some providers such as nurse practitioners, physician assistants, and clinical laboratories, assignment is mandatory; these providers can only bill the beneficiary the 20% coinsurance and any unmet deductible. For other Part B services, such as durable medical equipment, assignment is optional; providers may bill beneficiaries

³ For a complete description of Part D cost-sharing, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, by Jennifer O'Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer Boulanger, and Paulette Morgan.

for amounts above Medicare's recognized payment level and may do so without limit.

Recent Congressional Actions with Respect to Program Payments

Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been a major focus of deficit reduction legislation considered by Congress in recent years. With a few exceptions, reductions in program spending have been achieved largely through reductions in payments to providers, primarily hospitals and physicians that together represent about 63% of total program payments. These reductions stemmed, but did not eliminate year-to-year payment increases or overall program growth.

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) achieved significant savings to the Medicare program by slowing the rate of growth in payments to providers and by enacting structural changes to the program. A number of health care provider groups stated that actual Medicare benefit payment reductions resulting from BBA 97 were larger than were intended, leading to facility closings and other limits on beneficiary access to care. In November 1999, Congress passed a package of funding increases to mitigate the impact of some BBA 97 provisions on providers. This measure, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), is part of a larger measure known as the Consolidated Appropriations Act for 2000 (P.L. 106-113). Further adjustments were made by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), part of the larger Consolidated Appropriations Act, 2001 (P.L. 106-554). In addition to increasing Medicare payment rates, the subsequent legislation mandated the development or refinement of PPSs for different Medicare covered services. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, or MMA) contained a major benefit expansion in adding prescription drug coverage; Congress included a number of provisions that affected payments to providers, certain provisions that focused on constraining Medicare's spending, and changes to administrative and contracting procedures. Most recently, further modifications were made to Medicare payments in the Deficit Reduction Act of 2005 (P.L. 109-171, DRA).

This report provides a guide to Medicare payment rules by type of benefit, but does not include the outpatient prescription drug benefit under Part D. This report includes a summary of current payment policies and basic rules for updating payment amounts. It also provides the most recent update information for each type of service.

Medicare Payment Policies

Part A

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

Provider/service	General payment policy	General update policy	Most recent update
<p>Operating PPS for inpatient services provided by acute hospitals (Operating IPPS)</p>	<p>Medicare pays acute hospitals using a prospectively determined payment for each discharge. A hospital's payment for its operating costs is calculated using a national standardized amount adjusted by a wage index associated with the area where the hospital is located or where it has been reclassified. Payment also depends on the relative resource use associated with the diagnosis related group (DRG) to which the patient is assigned. Additional payments are made for: cases with extraordinary costs (outliers); indirect medical education (IME) (see below); and for hospitals serving a disproportionate share (DSH) of low-income patients (see below). IME and DSH payments are made through an adjustment within IPPS that results in additional monies being paid for each Medicare discharge. Additional payments may be made for cases that involve qualified new technologies that have been approved for special add-on payments. Hospitals in Hawaii and Alaska receive a cost-of-living adjustment</p>	<p>IPPS payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket (MB) index. This is a fixed price index that measures the change in the price of goods and services purchased by hospitals to create one unit of output. The update for operating IPPS is established by statute. Typically, hospitals receive less than the MB index for an update (sometimes referred to as a "diet COLA"). Under MMA, for FY2005-FY2007, hospitals that submit required quality data will receive the full MB update, those that do not submit the data will receive MB-0.4 percentage points. The reduction would apply for the applicable year and would not be taken into account in subsequent years. Under DRA, hospitals that do not submit required quality data in FY2007 and each subsequent year will have the applicable MB percentage reduced by two percentage points.</p>	<p>For FY2005, hospitals that submitted the required quality data receive the full MB increase of 3.3%. Hospitals that did not submit the quality data receive a reduced update of 2.9%. For FY2006, hospitals that submitted the required quality data receive the full MB increase of 3.7%. Hospitals that did not submit the quality data receive a reduced update of 3.3%.</p>

Provider/service	General payment policy	General update policy	Most recent update
	(COLA). Certain services are reimbursed on a cost basis outside of IPPS.		
Capital IPPS for short-term general hospitals (Capital IPPS)	Medicare's capital IPPS is structured similarly to its operating IPPS for short-term general hospitals. A hospital's capital payment is based on a prospectively determined federal payment rate, which is 3% higher for hospitals in large urban areas than for hospitals in other areas, depends on the DRG to which the patient is assigned, and is adjusted by a hospital's geographic adjustment factor (which is calculated from the hospital's wage index data). Capital IPPS includes an IME and DSH adjustment (see below). Additional payments are made for outliers (cases with significantly higher costs above a certain threshold). Certain hospitals may also qualify for additional payments under an exceptions process. A new hospital is paid 85% of its allowable Medicare inpatient hospital capital-related costs for its first two years of operation.	Updates to the capital IPPS are not established in statute. Capital rates are updated annually by the Centers for Medicare and Medicaid (CMS) according to a framework which considers changes in the prices associated with capital-related costs as measured by the capital input price index (CIPI) and other policy factors, including changes in case mix intensity, errors in previous CIPI forecasts, DRG recalibration, and DRG reclassification. Other adjustments include those that implement budget neutrality with respect to outlier payments, changes in the geographic adjustment factor, and exception payments.	The capital IPPS update for FY2005 is 0.7%, all of which is attributed to the current forecast of the CIPI available when the final rule was published; other adjustments included in the capital update framework cancelled each other out. The capital IPPS update for FY2006 is 0.99%. Most of this increase is caused by the current forecast of the CIPI available when the final rule was published.
Disproportionate share hospital adjustment	Approximately 2,800 hospitals receive the additional payments for each Medicare discharge based on a formula which incorporates the number of patient days provided to low-income Medicare beneficiaries (those who receive Supplemental Security Income (SSI)) and Medicaid recipients. A few urban	No specific update. The amount of DSH spending in any year is open-ended and varies by number of Medicare discharges as well as the type of patient seen in any given hospital.	CBO estimates DSH spending (in both operating and capital IPPS) at \$9.2 billion in FY2005 and \$9.45 billion in FY2006 in its March 2006 baseline.

Provider/service	General payment policy	General update policy	Most recent update
	<p>hospitals, known as “Pickle Hospitals,” receive DSH payments under an alternative formula that considers the proportion of a hospital’s patient care revenues that are received from state and local indigent care funds. The percentage add-on for which a hospital will qualify varies according to the hospital’s bed size or urban or rural location. Certain hospitals, such as sole community hospitals (SCHs, see below) and rural referral centers (RRC, see below) may qualify for special DSH treatment.</p>		
<p>Indirect Medical Education (IME) adjustment</p>	<p>The indirect medical education adjustment (IME) is one of two types of payments to teaching hospitals for graduate medical education (GME) costs (see also direct GME below). Medicare increases both its operating and capital IPPS payments to teaching hospitals; different measures of teaching intensity are used in the operating and capital IPPS. For both IPPS payments, however, the number of medical residents who can be counted for the IME adjustment is capped, based on the number of medical residents as of December 31, 1996. As established by BBA 97, teaching hospitals also receive IME payments for their Medicare+Choice discharges.</p>	<p>The IME adjustment is not subject to an annual update. BBA 97 reduced the IME adjustment in operating IPPS from a 7.7% increase for each 10% increase in a hospital’s ratio of interns to beds (IRB), a measure of teaching intensity in operating IPPS; by FY2001, the IME adjustment was to be 5.5%. However, the scheduled decreases were delayed by subsequent legislation. MMA provides an increased IME adjustment to 6.0% from April 1, 2004-September 30, 2004; during FY2005 the adjustment is 5.8%; during FY2006 the adjustment is 5.55%; and during FY2007 the adjustment is 5.35%; starting FY2008 and subsequently, the adjustment returns to 5.5%.</p>	<p>No specific update. The amount spent on IME depends in part on the number of Medicare discharges in teaching hospitals in any given year. CBO estimates the IME payments (for both capital and operating IPPS) to be about \$5.8 billion in FY2005 and \$6.0 billion in FY2006 in its March 2006 baseline.</p>

Provider/service	General payment policy	General update policy	Most recent update
Direct graduate medical education payments	Direct GME costs are excluded from IPPS and paid outside of the DRG payment on the basis of updated hospital-specific costs per resident amount (PRA), the number of weighted full-time equivalent (FTE) residents, and Medicare's share of total patient days in the hospital (including those days attributed to Medicare+Choice enrollees). There is a hospital-specific cap on the number of residents in the hospital for direct GME payments. Also, the hospital's FTE count is based on a three-year rolling average; a specific resident may count as half of a FTE, depending on the number of years spent as a resident and the length of the initial training associated with the specialty. Certain combined primary care residency programs receive special recognition in this count. Depending upon the circumstances, direct GME payments can be made to nonhospital providers.	In general, direct GME payments are updated by the increase in the consumer price index for all urban consumers (CPI-U). As established by BBRA and subsequently amended, however, the update amount that any hospital receives depends upon the relationship of its PRA to the national average PRA. Hospitals with PRAs below the floor (85% of the locality-adjusted, updated, and weighted national PRA) are raised to the floor amount. Teaching hospitals with PRAs above the ceiling amount (140% of the national average, adjusted for geographic location) will receive a lower update than other hospitals (CPI-U minus two percentage points) for FY2003-FY2013. Hospitals that have PRAs between the floor and ceiling receive the CPI-U.	Hospitals below 140% of the national average from FY2004-FY2013 receive an update of CPI-U. Hospitals above 140% of the national average for that time period will receive no update. CBO estimates direct GME payments of \$1.7 billion in FY2005 and FY2006 in its March 2006 baseline.

2. Hospitals Receiving Special Consideration Under Medicare's IPPS

Provider/service	General payment policy	General update policy	Most recent update
<p>Sole Community Hospitals (SCHs) — facilities located in geographically isolated areas and deemed to be the sole provider of inpatient acute care hospital services in a geographic area based on distance, travel time, severe weather conditions, and/or market share as established by specific criteria set forth in regulation (42 CFR 412.92).</p>	<p>An SCH receives the higher of the following payment rates as the basis of reimbursement: the current IPPS base payment rate, or its hospital-specific per-discharge costs from either FY1982, 1987, or 1996, updated to the current year. An SCH may receive additional payments if the hospital experiences a decrease of more than 5% in its total inpatient cases due to circumstances beyond its control. An SCH receives special consideration for reclassification into a different area. Starting for services on January 1, 2006, CMS increased outpatient prospective payment system (OPPS) payments to rural SCHs by an additional 7.1%.</p>	<p>Target amounts for SCHs are updated by an “applicable percentage increase” which is specified by statute and is often comparable to the IPPS update.</p>	<p>For FY2005, hospitals that submitted the required quality data receive the full MB increase of 3.3%. Hospitals that did not submit the quality data receive a reduced update of 2.9%. For FY2006, hospitals that submitted the required quality data receive the full MB increase of 3.7%. Hospitals that did not submit the quality data receive a reduced update of 3.3%. These updates are also used to increase the hospital-specific rate applicable to an SCH.</p>
<p>Medicare Dependent Hospitals (MDHs) — small rural hospitals with a high proportion of patients who are Medicare beneficiaries (have at least 60% of acute inpatient days or discharges attributable to Medicare in FY1987 or in two of the three most recently audited cost reporting periods). As specified in</p>	<p>BBA 97 reinstated and extended the MDH classification, starting on October 1, 1997 to October 1, 2001. The sunset date for the MDH classification was subsequently extended to September 30, 2011 by DRA. Until October 1, 2006, an MDH is paid 50% of the amount that the federal rate is exceeded by the hospital’s target amount based on either its updated FY1982 or FY1987 costs. DRA provided that an MDH would be able to elect payments based on 50% of its FY2002 hospital-specific costs starting October 1, 2006. An</p>	<p>Target amounts for MDHs are updated by an “applicable percentage increase” which is specified by statute and is often comparable to the IPPS update.</p>	<p>For FY1996 and thereafter, the update for MDHs is the same as for all IPPS hospitals. These updates are also used to increase the hospital-specific rate applicable to an MDH. For FY2005, hospitals that submitted the required quality data receive the full MB increase of 3.3%. Hospitals that did not submit the quality data receive a reduced update of 2.9%. For FY2006, hospitals that submitted the required quality data receive the full MB increase of 3.7%. Hospitals that did not submit the quality data</p>

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Provider/service	General payment policy	General update policy	Most recent update
<p>regulation (42 CFR 412.108), they cannot be an SCH and must have 100 or fewer beds.</p>	<p>MDH's payments would be based on 75% of the adjusted hospital-specific costs starting for discharges on October 1, 2006. An MDH may receive additional payments if its inpatient cases decline more than 5% due to circumstances beyond its control.</p>		<p>receive a reduced update of 3.3%.</p>
<p>Rural Referral Centers (RRCs) — relatively large hospitals, generally in rural areas, that provide a broad array of services and treat patients from a wide geographic area as established by specific criteria set forth in regulation. (42 CFR 412.96).</p>	<p>RRCs payments are based on the IPPS for short-term general hospitals. Qualifying RRCs receive a higher DSH adjustment than do other rural hospitals. Also, RRCs receive preferential consideration for reclassification to a different area.</p>	<p>RRCs receive the operating and capital IPPS updates specified for short-term general hospitals.</p>	<p>See updates specified for operating and capital IPPS for short-term general hospitals.</p>

3. IPPS-Exempt Hospitals and Distinct Part Units

Provider/service	General payment policy	General update policy	Most recent update
<p>Inpatient Rehabilitation Facilities (IRFs) — freestanding hospitals and hospital-based distinct part units that meet the modified “75% rule” and certain specified conditions of participation. The rule, which was to become effective July 1, 2004, has a tiered three-year phase in period; for the first year, at least 50% of an IRF’s inpatient population must have at least one of the qualifying medical conditions. Enforcement of the modified 75% rule was initially delayed by legislative action. Most recently, DRA established the IRF threshold at 60% through June 30, 2007, at 65% starting July 1, 2007, and at 75% beginning on July 1, 2008, and subsequently. A patient must receive rehabilitation services for one of 13</p>	<p>As of January 1, 2002, Medicare’s payments to a rehabilitation facility are based on a fully implemented IRF-PPS and 100% of the federal rate which is a fixed amount per discharge. This PPS encompasses both capital and operating payments to IRFs, but does not cover the costs of approved educational programs, bad debt expenses, or blood clotting factors, which are paid for separately. The IRF-PPS payment for any Medicare discharge will vary depending on the patient’s impairment level, functional status, comorbidity conditions, and age. These factors determine which of the 380 Case Mix Groups (CMGs) is assigned to the inpatient stay. Five other CMGs are used for patients discharged before the fourth day (short stay outliers) and for those who die in the facility. Generally, IRF payments are reduced or increased for certain case level adjustments, such as early transfers, short-stay outliers, patients who die before transfer, and high cost outliers. Payments also depend upon facility-specific adjustments to accommodate variations in area wages, percentage of low income patients (LIP) served by the hospital (a DSH adjustment), and rural location (rural IRFs receive</p>	<p>Starting in FY2006, the IRF-PPS update is based on the MB reflecting 2002 cost structures from rehabilitation, long-term care, and psychiatric hospitals (RLP-MB). The RLP-MB includes an update estimate for capital as well as operating costs.</p>	<p>The update for FY2005 is 3.1%. The update for FY2006 is 3.6%. In FY2006, the IRF-IPPS included a one-time reduction of 1.9% to account for coding changes.</p>

Provider/service	General payment policy	General update policy	Most recent update
<p>conditions including stroke, spinal cord injury, brain injury, neurological disorder, burns, and certain arthritis related conditions.</p>	<p>increased payments, about 19% more than urban IRFs.) Starting in FY2006, an IME adjustment is included; IRFs in Alaska and Hawaii do not receive a COLA adjustment. The IRF-PPS is not required to be budget neutral; total payments can exceed the amount that would have been paid if this PPS had not been implemented.</p>		
<p>Long-Term Care Hospitals and satellite or onsite providers (LTCHs) — acute general hospitals that are excluded from IPPS with a Medicare inpatient average length of stay (ALOS) greater than 25 days.</p>	<p>Effective October 1, 2002, LTCHs are paid on a discharge basis under a DRG-based PPS, subject to a five-year transition period. A LTCH may opt to be paid based on 100% of the federal prospective rate. A new LTCH must be paid on 100% of the federal rate. The LTCH-PPS encompasses payments for both operating and capital-related costs of inpatient care but does not cover the costs of approved educational programs, bad debt expenses, or blood clotting factors which are paid for separately. The LTCH-PPS payment for any Medicare discharge will vary depending on the patient's assignment into one of 510 LTCH-DRGs, which are based on reweighted IPPS DRGs. Payments for specific patients may be increased or reduced because of case-level adjustments. Payments also depend upon facility-specific adjustments such as variations in area wages (implemented over a five-year transition period) and include a COLA for</p>	<p>Presently, the LTCH-PPS update is based upon the MB for excluded hospitals (those paid under IPPS). This MB is based on cost report data from Medicare participating IRFs, psychiatric facilities, and long term, children's, and changer hospitals, which were subject to the limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA MB payment only includes operating costs, so the update is based on a modified TEFRA MB that reflects capital costs. The Medicare LTCH update incorporates a budget-neutrality factor as well. CMS has changed the effective date of the annual update from October 1 to July 1 of each year, starting July 2003. During the five-year transition period, CMS calculates a budget-neutrality offset to account for the ability of LTCHs to elect payment based on the transition blend methodology or on 100% of the federal payment amount,</p>	<p>The increase to the LTCH federal rate beginning July 1, 2004 is 3.1%. For discharges starting in July 1, 2005, the update is 3.4%.</p>

Provider/service	General payment policy	General update policy	Most recent update
	<p>hospitals in Alaska and Hawaii. No adjustments are made for the percentage of low income patients served by the hospital (DSH), rural location, or IME. The LTCH-PPS is required to be budget neutral; total payments must equal the amount that would have been paid if PPS had not been implemented.</p>	<p>whichever results in greater Medicare payments. The election option offset for the 2005 rate year was estimated at \$15 million, causing a reduction in LTCH payments of 0.5% (0.995). No such reduction occurred in the following rate year (RY2006).</p>	
<p>Psychiatric hospitals and distinct part units — include those primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of people with mental illness.</p>	<p>Until January 1, 2005, services provided in inpatient psychiatric facilities (IPF) had been paid on a reasonable cost basis, subject to modified TEFRA payment limitations and incentives. As directed by BBRA, a budget-neutral per-diem-based PPS for inpatient psychiatric services was implemented for these hospitals and units. Established with a three-year transition period, the IPF-PPS incorporates patient-level adjustments for specified DRGs, selected comorbidities, and in certain cases, age of the patient. Facility-level adjustments for relative wages, teaching status and rural location are also included. IPFs in Hawaii and Alaska will receive a COLA adjustment. Medicare per diem payments are higher in the earlier days of the psychiatric stay. Also, the per diem payment for the first day of each stay is higher in IPFs with qualifying (full-service) emergency departments than in other IPFs. An outlier policy for high-cost</p>	<p>Initially, the IPF-PPS update in future years was to be based on the modified TEFRA MB that reflects capital costs described previously. However, the proposed rule issued in January 2006 announced that, subject to public comment, the update will incorporate the RPL-MB as well. The IPF-PPS payments must be projected to equal the amount of total payments that would have been made under the prior payment system. The initial calculation of the per diem payment included a 16.33% reduction to account for outlier payments, the stop-loss provision and a behavioral offset (to account for changing utilization under the new payment system).</p>	<p>The IPF-PPS system was implemented for discharges beginning on January 1, 2005. The first update to the new system is scheduled for July 1, 2006.</p>

Provider/service	General payment policy	General update policy	Most recent update
	<p>cases is included. Patients who are discharged from an IPF and return within three days are considered readmissions of the same case. Finally, under the stop-loss provision, during the three-year transition period, an IPF is guaranteed at least 70% of the aggregate payments that would be made under the prior payment system.</p>		
<p>Children’s and cancer hospitals:</p> <p><i>Children’s hospitals</i> are those engaged in furnishing services to inpatients who are predominantly individuals under the age of 18.</p> <p><i>Cancer hospitals</i> 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 another entity); and have at least 50% of their discharges with a diagnosis of neoplastic disease. See 42</p>	<p>Children’s and cancer hospitals are paid on a reasonable cost basis, subject to TEFRA payment limitations and incentives. Each provider’s reimbursement is subject to a ceiling or target amount that serves as an upper limit on operating costs. Depending upon the relationship of the hospital’s actual costs to its target amount, these hospitals may receive relief or bonus payments as well as additional bonus payments for continuous improvement; i.e., facilities whose costs have been consistently less than their limits may receive additional money. Newly established hospitals receive special treatment. Providers that can demonstrate that there has been a significant change in services and/or patients may receive exceptions payments. The capital costs for these hospitals are reimbursed on a reasonable cost basis.</p>	<p>An update factor for reimbursement of operating costs is established by statute. Starting in FY2006, IPPS operating MB increase is used to update the target amounts. The amount of increase received by any specific hospital will depend upon the relationship of the hospital’s costs to its target amount. There is no specific update for capital costs.</p>	<p>The update for FY2005 is 3.3%. The update for FY2006 is 3.7%.</p>

Provider/service	General payment policy	General update policy	Most recent update
CFR 412.23(f).			
<p>Critical Access Hospitals (CAHs) are limited-service facilities that are located more than 35 miles from another hospital (15 miles in certain circumstances) or designated by the state as a necessary provider of health care; offer 24-hour emergency care; have no more than 25 acute care inpatient beds and have a 96-hour average length of stay. Beds in distinct-part skilled nursing facility, psychiatric or rehabilitation units operated by a CAH do not count toward the bed limit.</p>	<p>Medicare pays CAHs on the basis of the reasonable costs of the facility for inpatient and outpatient services. CAHs may elect either a cost-based hospital outpatient service payment or an all-inclusive rate which is equal to a reasonable cost payment for facility services plus 115% of the fee schedule payment for professional services. Ambulance services that are owned and operated by CAHs are reimbursed on a reasonable cost basis if these ambulance services are 35 miles from another ambulance system. MMA provided that inpatient, outpatient, and swing bed services provided by CAHs will be paid at 101% of reasonable costs for cost reporting periods beginning January 1, 2004.</p>	<p>No specific update policy.</p>	<p>No specific update policy.</p>

4. Skilled Nursing Facility (SNF) Care

Provider/service	General payment policy	General update policy	Most recent update
SNF care	<p>BBA 97 changed payment for SNF care from a cost-based retrospective reimbursement system to a PPS. The PPS payments are based on a daily (“per-diem”) urban or rural base payment amount that is adjusted for case mix and area wages.</p> <p>The federal per diem payment covers all the services provided to the beneficiary that day including room and board, nursing, therapy, and prescription drugs. Some care costs are excluded from PPS and paid separately such as physician visits, dialysis and certain high cost prosthetics and orthotics.</p> <p>The case-mix adjustment to the federal per diem rate adjusts payments for the treatment and care needs of Medicare beneficiaries and is made using a system called resource utilization groups (RUGs). The RUGs system uses patient assessments to assign a beneficiary to one of 44 categories and to determine the payment for the beneficiary’s care. Patient assessments are done at various times during a patient’s stay and the RUG category a beneficiary is placed in can change with changes in the beneficiary’s</p>	<p>The urban and rural federal per diem payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the SNF market basket index. This index measures changes in the costs of goods and services purchased by SNFs.</p> <p>BIPA 2000 provided for the following updates:</p> <p>FY2001 = MB FY2002 = MB - 0.5 FY2003 = MB - 0.5 FY2004 and subsequent years = MB</p> <p>The MB level increase in the update was unchanged by MMA.</p> <p>At the end of FY2002, two temporary add-ons expired: a 4% increase in base payment rates that was in effect for FY2001 and FY2002 from BBRA and a 16.66% increase in the nursing component of the payment rates that was in effect from April 1, 2001 until September 30, 2002, from BIPA. The expiration of these add-on resulted in a decrease in payments of \$1.4 billion.</p>	<p>For FY2006, SNFs received the full market basket increase of 3.1 percentage points. The net effect of all SNF fee-for-service payment changes (see General Update Policy column), however, will likely result in a total net increase of 0.1 percentage points for FY2006 (Medpac 2006, Report to Congress: Medicare Payment Policy).</p> <p>For FY2005, the SNF market basket estimated update was 3.1 percentage points, while the actual increase was 3.3 percentage points. Since the difference between the estimated and actual amounts of change did not exceed the 0.25 percentage point threshold, the payment rates for FY2005 do not include a forecast error adjustment and remain at 3.1 percentage points.</p> <p>For FY2004, the update was 3.0%. For FY2004, SNFs received an additional 3.26% increase to account for cumulative forecast error since SNF PPS began on July 1, 1998.</p>

Provider/service	General payment policy	General update policy	Most recent update
	<p>condition; the daily SNF PPS payment will change as well.</p> <p>The final adjustment to the daily payment rate is to account for variations in area wages and uses the hospital wage index.</p> <p>MMA increased payments for AIDS patients in SNFs by 128% starting October 1, 2004.</p> <p>Unlike other PPSs, the SNF PPS statute does not provide for an adjustment for extraordinarily costly cases (an “outlier” adjustment).</p>	<p>Another temporary increase in 26 RUGs also expired. This add-on increased payments by about \$1 billion per year and was scheduled to expire upon the implementation of a refined RUG system by the Secretary of DHHS. This refined RUG system was finalized in the Final Rule (70 FR 45026) and began implementation in FY2006. The new system added nine new RUGS to the patient classification systems and increased nursing weights associated with all RUG groups. Combined, CMS estimates that hospital-based SNFs in aggregate will experience payment increases, while freestanding SNFs in aggregate will experience payment reductions.</p>	

5. Hospice Care

Provider/Service	General payment policy	General update policy	Most recent update
Hospice care	<p>Payment for hospice care is based on one of four prospectively determined rates, which correspond to four different levels of care, for each day a beneficiary is under the care of the hospice. The four rate categories are: routine home care, continuous home care, inpatient respite care, and general inpatient care. Payment rates are adjusted to reflect differences in area wage levels using the hospital wage index. Payments to a hospice are subject to an aggregate cap that is determined by multiplying the cap amount for a given year by the number of Medicare beneficiaries who receive hospice services during the year. Limited cost-sharing applies to outpatient drugs and respite care.</p>	<p>The prospective payment rates are updated annually by the increase in the hospital market basket. The hospice cap amount is adjusted annually by the percentage change in the medical care expenditure category of the CPI-U. However, BBA 97 reduced the hospice payment update to the market basket minus 1.0 percentage point each year from FY1998-FY2002. BBRA increased the hospice payments 0.5% for FY2001 and 0.85% for FY2002. This increase was not included in the base for updating the payment rate in subsequent years. BIPA increased payment rates by five percentage points beginning April 1, 2001-September 30, 2001. This increase was included in the base for subsequent updates. Since FY2003 updates have been at the full hospital market basket percentage increase.</p>	<p>National hospice payment rates for care furnished during FY2006 are as follows:</p> <p>Routine home care — \$126.49 per day Continuous home care — \$738.26, full rate = 24 hours of care, or \$30.76 per hour; Inpatient respite care — \$130.85 per day; General inpatient care — \$5642.69 per day.</p> <p>The hospice cap for the period November 1, 2004-October 31, 2005 was \$19,635.67 per beneficiary per year.</p>

Part B

1. Physicians

Provider/service	General payment policy	General update policy	Most recent update
Physicians	<p>Payments for physicians services are made on the basis of a fee schedule. The fee schedule assigns relative values to services. These relative values reflect physician work (based on time, skill, and intensity involved), practice expenses, and malpractice expenses. The relative values are adjusted for geographic variations in the costs of practicing medicine. These geographically adjusted relative values are converted into a dollar payment amount by a conversion factor. Assistants-at-surgery services are paid 16% of the fee schedule amount.</p> <p>Anesthesia services are paid under a separate fee schedule (based on base and time units) with a separate conversion factor.</p> <p>Payments equal 80% of the fee schedule amount; patients are liable for the remaining 20%. (Payments for certain mental health services equal 50% of the fee schedule amounts; patients are liable for the other 50%). Assignment is optional; balance billing limits apply on</p>	<p>The conversion factor is updated each year by a formula specified in law. The update percentage equals the Medicare Economic Index (MEI, which measures inflation) subject to an adjustment to match spending under the cumulative sustainable growth rate (SGR) system. (The SGR is linked, in part, to changes in the gross domestic product.) The adjustment sets the conversion factor so that projected spending for the year will equal allowed spending by the end of the year. In no case can the conversion factor update be more than three percentage points above nor more than seven percentage points below the MEI. Application of the SGR system led to a 5.4% reduction in the conversion factor in 2002. An additional 4.4% reduction was slated to take effect in 2003. However, P.L. 108-7 allowed for revisions in previous estimates used for the SGR calculation, thereby permitting an update of 1.6% effective March 1, 2003. MMA provided that the update to the conversion factor for 2004 and 2005 could not be less than 1.5% and would be exempt from the budget-neutrality</p>	<p>The 2006 conversion factor is \$37.8975 (the same as 2005).</p> <p>The 2006 anesthesia conversion factor is \$17.7594 (the same as 2005).</p>

Provider/service	General payment policy	General update policy	Most recent update
	non-assigned claims.	adjustment. DRA froze the 2006 rate at the 2005 level.	

2. Nonphysician Practitioners

Provider/service	General payment policy	General update policy	Most recent update
(a) Physician Assistants	<p>Separate payments are made for physician assistant (PA) services, when provided under the supervision of a physician, but only if no facility or other provider charge is paid. Payment is made to the employer (such as a physician). The PA may be in an independent contractor relationship with the employer.</p> <p>The recognized payment amount equals 85% of the physician fee schedule amount (or, for assistant-at-surgery services, 85% of the amount that would be paid to a physician serving as an assistant-at-surgery). Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory for PA services.</p>	See physician fee schedule.	See physician fee schedule.
(b) Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)	Separate payments are made for NP or CNS services, provided in collaboration with a physician, but only if no other facility or other provider charge is paid.	See physician fee schedule.	See physician fee schedule.

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Provider/service	General payment policy	General update policy	Most recent update
	<p>The recognized payment amount equals 85% of the physician fee schedule amount (or, for assistant-at-surgery services, 85% of the amount that would be paid to a physician serving as an assistant-at-surgery). Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory.</p>		
(c) Nurse midwives	<p>The recognized payment amount for certified nurse midwife services equals 65% of the physician fee schedule amount. Nurse midwives can be paid directly. Medicare payments equal 80% of this amount; patients are liable for the remaining 20%. Assignment is mandatory.</p>	See physician fee schedule.	See physician fee schedule.
(d) Certified Registered Nurse Anesthetists (CRNAs)	<p>CRNAs are paid under the same fee schedule used for anesthesiologists. Payments furnished by an anesthesia care team composed of an anesthesiologist and a CRNA are capped at 100% of the amount that would be paid if the anesthesiologist was practicing alone. The payments are evenly split between each practitioner. CRNAs can be paid directly. Assignment is mandatory for services provided by CRNAs. Regular Part B cost-sharing applies.</p>	See physician fee schedule.	See physician fee schedule.

CRS-21

Provider/service	General payment policy	General update policy	Most recent update
(e) Clinical Psychologists and Clinical Social Workers	<p>The recognized payment amount for services provided by a clinical social worker is equal to 75% of the physician fee schedule amount.</p> <p>Services in connection with the treatment of mental, psychoneurotic, and personality disorders of a patient who is not a hospital inpatient are subject to the mental health services limitation. In these cases Medicare pays 50% of incurred expenses and the patient is liable for the remaining 50%. Otherwise, regular Part B cost-sharing applies. Assignment is mandatory for services provided by clinical psychologists and clinical social workers.</p>	See physician fee schedule.	See physician fee schedule.
(f) Outpatient physical or occupational therapy services	<p>Payments are made under the physician fee schedule.</p> <p>In 1999, an annual \$1,500 per beneficiary limit applied to all outpatient physical therapy services (including speech-language pathology services), except for those furnished by a hospital outpatient department. A separate \$1,500 limit applied to all outpatient occupational therapy services except for those furnished by hospital outpatient departments. Therapy services furnished as incident to physicians professional services were included in these limits.</p>	Updates in fee schedule payments are dependent on the update applicable under the physician fee schedule. The \$1,500 limits were to be increased by the increase in the MEI beginning in 2002; however, application of the limits was suspended until September 1, 2003. At that time the limits were \$1,590. MMA suspended the application of the limits beginning December 8, 2003-December 31, 2005. The limits were restored January 1, 2006; the 2006 limits are \$1,740. DRA requires the Secretary to establish an exceptions process for certain medically necessary services.	See physician fee schedule.

Provider/service	General payment policy	General update policy	Most recent update
	<p>The \$1,500 limits were to apply each year. However, no limits applied in 2000, 2001, and 2002. These applied again from September 2003- December 8, 2003.</p> <p>Regular Part B cost-sharing applies. Assignment is optional for services provided by therapists in independent practice; balance billing limits apply for non-assigned claims. Assignment is mandatory for other therapy services.</p>		

3. Clinical Diagnostic Laboratory Services

Provider/service	General payment policy	General update policy	Most recent update
Clinical diagnostic laboratory services	Clinical lab services are paid on the basis of areawide fee schedules. The fee schedule amounts are periodically updated. There is a ceiling on payment amounts equal to 74% of the median of all fee schedules for the test. Assignment is mandatory. No cost-sharing is imposed.	Generally, the Secretary of HHS is required to adjust the payment amounts annually by the percentage change in the CPI, together with such other adjustments as the Secretary deems appropriate. Updates were eliminated for 1998 through 2002. MMA eliminated updates for 2004-2008.	The fee schedules were updated by 1.1% in 2003 . No update was made for 2004, 2005, or 2006 .

4. Preventive Services

Provider/service	General payment policy	General update policy	Most recent update
Pap smears; pelvic exams	Medicare covers screening pap smears and screening pelvic exams once every two years; annual coverage is authorized for women at high risk. Payment is based on the clinical diagnostic laboratory fee schedule. Assignment is mandatory. No cost-sharing is imposed.	See clinical laboratory fee schedule. A national minimum payment amount applies for pap smears.	See clinical laboratory fee schedule. Minimum payment for pap smears in 2006 is \$14.76 (the same as 2005).
Screening mammograms	Coverage is authorized for an annual screening mammogram. Payment is made under the physician fee schedule. The deductible is waived; regular Part B coinsurance applies. Assignment is optional. Balance billing limits apply on non-assigned claims.	See physician fee schedule.	See physician fee schedule.
Colorectal screening	Coverage is provided for the following procedures for the early detection of colon cancer: (1) screening fecal occult blood tests (for persons over 50, no more than annually); (2) screening flexible sigmoidoscopy (for persons over 50, no more than once every four years and 10 years after a screening colonoscopy for those not at high risk for colon cancer); (3) screening flexible colonoscopy for high-risk individuals (limited to one every two years) and for those not at high risk, every 10 years or four years after a screening sigmoidoscopy; and (4) barium enemas (as	See physician fee schedule and lab fee schedule.	See physician fee schedule and lab fee schedule.

Provider/service	General payment policy	General update policy	Most recent update
	<p>an alternative to either a screening flexible sigmoidoscopy or screening colonoscopy in accordance with the same screening parameters established for those tests).</p> <p>Payments are based on rates paid for the same procedure when done for a diagnostic purpose. Fecal occult blood tests are paid under the lab fee schedule; other tests are paid under physician fee schedule. If a sigmoidoscopy or colonoscopy results in a biopsy or removal of a lesion, it would be classified and paid as the procedure with such biopsy or removal, rather than as a diagnostic test. Assignment is mandatory for fecal occult blood tests and no cost-sharing applies. Assignment is optional for sigmoidoscopies and colonoscopies. DRA specified that the Part B deductible does not apply for screenings, effective January 1, 2007. Balance billing limits apply on non-assigned claims.</p>		
Prostate cancer screening	Medicare covers an annual prostate cancer screening test. Payment is made under the physician fee schedule.	See physician fee schedule.	See physician fee schedule.
Glaucoma screening	Medicare covers an annual glaucoma screening for persons with diabetes, persons with a family history of glaucoma and African-Americans age 50 and over. Payment is made under the physician fee	See physician fee schedule.	See physician fee schedule.

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Provider/service	General payment policy	General update policy	Most recent update
	schedule.		
Diabetes outpatient self-management training	Medicare covers services furnished by a certified provider. Payment is made under the physician fee schedule.	See physician fee schedule.	See physician fee schedule.
Medical nutrition therapy services	Coverage is authorized for certain individuals with diabetes or renal disease. Payment equals 85% of the amount established under the physician fee schedule for the service if it had been furnished by a physician.	See physician fee schedule.	See physician fee schedule.
Bone mass measurements	Bone mass measurements are covered for certain high-risk individuals. Payments are made under the physician fee schedule. In general, services are covered if they are provided no more frequently than once every two years.	See physician fee schedule.	See physician fee schedule.
Ultrasound screenings for abdominal aortic aneurysms	Effective January 1, 2007, ultrasound screenings for abdominal aortic aneurysms are covered for individuals who: (1) receive a referral for such screening during the initial preventive services exam; (2) have not had such a screening paid for by Medicare; and (3) have a family history of abdominal aortic aneurysm or manifest certain risk factors.	See physician fee schedule.	See physician fee schedule.

5. Telehealth

Provider/Service	General payment policy	General update policy	Most recent update
Telehealth services	Medicare pays for services 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 is equal to the amount that would be paid under the physician fee schedule if the service had been furnished without a telecommunications system. A facility fee is paid to the originating site (the site where the beneficiary is when the service is provided).	See physician fee schedule. The facility fee equals the amount established for the preceding year, increased by the percentage increase in the MEI.	See physician fee schedule. The 2006 facility fee is \$22.47 (compared to \$21.86 in 2504).

6. Durable Medical Equipment (DME)

Provider/service	General payment policy	General update policy	Most recent update
Durable Medical Equipment (DME)	DME is paid on the basis of a fee schedule. Items are classified into five groups for purposes of determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than \$150 or which are purchased at least 75% of the times; (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to	In general, fee schedule amounts are updated annually by the CPI-U. Updates were eliminated for 1998-2000; payments were increased by the CPI-U for 2001; and payments were frozen for 2002. MMA eliminated the updates for 2004-2008.	The update for 2003 was 1.1%. As required by MMA, there were no updates for 2004, 2005, and 2006 .

Provider/service	General payment policy	General update policy	Most recent update
	<p>as capped rental items. In general, fee schedule rates are established locally and are subject to national limits. The national limits have floors and ceilings. The floor is equal to 85% of the weighted average of all local payment amounts and the ceiling is equal to 100% of the weighted average of all local payment amounts. Assignment is optional. Balance billing limits do not apply on non-assigned claims. Regular Part B cost-sharing applies.</p> <p>MMA requires that, beginning in 2007, the Secretary begin a program of competitive acquisition for DME. Competitive acquisition is to begin in 10 metropolitan statistical areas (MSAs) in 2007, expand to 80 MSAs in 2008, and expand to additional areas in 2009. The Secretary is authorized to phase in competitive acquisition among the highest cost and highest volume items and services or those items and services that the Secretary determines have the largest savings potential.</p>		

7. Prosthetics and Orthotics

Provider/service	General payment policy	General update policy	Most recent update
Prosthetics and orthotics	Prosthetics and orthotics are paid on the basis of a fee schedule. These rates are established regionally and are subject to national limits which have floors and ceilings. The floor is equal to 90% of the weighted average of all regional payment amounts and the ceiling is equal to 120% of the weighted average of all regional payment amounts. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost-sharing applies.	Fee schedule amounts are updated annually by the CPI-U. MMA eliminated the updates for 2004-2006.	The update for 2003 was 1.1%. As required by MMA, there were no updates for 2004, 2005 and 2006 .

8. Surgical Dressings

Provider/service	General payment policy	General update policy	Most recent update
Surgical Dressings	Surgical dressings are paid on the basis of a fee schedule. Payment levels are computed using the same methodology as the durable medical equipment fee schedule (see above). Assignment is optional; balance billing limits do not apply to non-assigned claims. Regular Part B cost-sharing applies.	See durable medical equipment fee schedule.	The update for 2003 was 1.1%. There was no update for 2004, 2005 , and 2006 .

9. Parenteral and Enteral Nutrition (PEN)

Provider/service	General payment policy	General update policy	Most recent update
Parenteral and Enteral Nutrition (PEN)	Parenteral and enteral nutrients, equipment, and supplies are paid on the basis of the PEN fee schedule. Prior to 2002, PEN was paid on a reasonable charge basis (see below under Miscellaneous Items and Services). The fee schedule amounts are based on payment amounts made on a national basis to PEN suppliers under the reasonable charge system. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost-sharing applies.	Fee schedule amounts are updated annually by the CPI-U.	The 2006 rate increased by the CPI-U, 2.5%.

10. Miscellaneous Items and Services

Provider/service	General payment policy	General update policy	Most recent update
Miscellaneous services	Miscellaneous items and services here refers to those services still paid on a reasonable charge basis. Included are such items as splints, casts, home dialysis supplies and equipment, therapeutic shoes, certain intraocular lenses, blood products, and transfusion medicine. These charges may not exceed any of the following fee screens: (1) the supplier's customary charge for the item, (2) the prevailing	Payments for reasonable charge items are calculated annually. Carriers determine a supplier's customary charge level. Prevailing charges may not be higher than 75% of the customary charges made for similar items and services in the locality during the 12-month period of July 1- June 30 of the previous calendar year. The inflation-indexed charge is updated by the CPI-U.	The update to the inflation-indexed charge for 2006 is 2.5% (compared to 3.3% for 2005).

Provider/service	General payment policy	General update policy	Most recent update
	charge for the item in the locality, (3) the charges made to the carrier's policyholders or subscribers for comparable items, (4) the inflation-indexed charge. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost-sharing applies.		

11. Ambulatory Surgical Centers (ASCs)

Provider/service	General Payment policy	General update policy	Most recent update
Medicare Certified Ambulatory Surgical Centers (ASCs)	Medicare uses a fee schedule to pay for the facility services related to a surgery provided in an ASC. The associated physician services (surgery and anesthesia) are reimbursed under the physician fee schedule. CMS maintains the list of approved ASC procedures which is required to be updated every two years. Presently over 2,500 procedures are approved for ASC payment and categorized into one of nine payment groups that comprise the ASC facility fee schedule. The nine ASC payment rates reflect the national median cost of procedures in that group; these rates are adjusted to reflect geographic price variation using a hospital wage index. Payments are also adjusted when multiple	MMA established that in FY2004, starting April 1, 2004, the ASC update is the CPI-U (estimated as of March 31, 2003) minus 3.0 percentage points. MMA eliminated the payment update for FY2005, changed the update cycle to a calendar year from a fiscal year, and eliminated the updates for calendar years 2006-2009. MMA also established that a revised payment system for surgical services furnished in an ASC will be implemented on or after January 1, 2006, and not later than January 1, 2008. Total payments under the new system should be equal to the total projected payments under the old system.	As mandated by MMA, ASCs received an 0% update in FY2005, and the last quarter of calendar year 2005 and in CY2006. Effective for services on and after April 1, 2004, the base rates (prior to geographic adjustments) are: Payment Group 1 — \$333 Payment Group 2 — \$446 Payment Group 3 — \$510 Payment Group 4 — \$630 Payment Group 5 — \$717 Payment Group 6 — \$826 (\$676 + \$150 for an intraocular lens) Payment Group 7 — \$995 Payment Group 8 — \$973 (\$823 + \$150 for an intraocular lens)

Provider/service	General Payment policy	General update policy	Most recent update
	surgical procedures are performed at the same time. Generally, the ASC will receive full payment for the most expensive procedure and will receive 50% payment for the other procedures.		Payment Group 9 — \$1,339

12. Hospital Outpatient Services

Provider/service	General payment policy	General update policy	Most recent update
Hospital Outpatient Departments (HOPDs)	Under HOPD-PPS, which was implemented in August 2000, the unit of payment is the individual service or procedure as assigned to one of about 570 ambulatory payment classifications (APCs). To the extent possible, integral services and items are bundled within each APC, specified new technologies are assigned to new technology APCs until clinical and cost data is available to permit assignment into a clinical APC. Medicare's payment for HOPD services is calculated by multiplying the relative weight associated with an APC by a conversion factor. For most APCs, 60% of the conversion factor is geographically adjusted by the IPPS wage index. Except for new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC.	The conversion factor is updated on a calendar year schedule. These annual updates are based on the hospital MB.	For CY2005 , the IPPS MB was 3.3%. This increase was adjusted by the required wage index and pass-through budget-neutrality factors. The final CY2005 conversion factor is \$56.983. For CY2006 , the IPPS MB was 3.7%. This increase was adjusted by the required wage index and pass-through budget-neutrality factors, including one to account for the rural SCH payment adjustment. The final CY2006 conversion factor was \$59.511.

Provider/service	General payment policy	General update policy	Most recent update
	<p>Certain APCs with significant fluctuations in their relative weights will have the calculated change dampened. The HOPD-PPS also includes budget-neutral pass-through payments for new technology and budget-neutral outlier payments. Cancer and children's hospitals have a permanent hold harmless protection from the HOPD-PPS. HOPDs in rural hospitals with 100 or fewer beds (that are not SCHs) will receive at least 95% of the payment it would have received under the prior payment system during CY2006. The percentage will be reduced to 90% during 2007 and 85% during 2008. Starting for services on January 1, 2006, rural SCHs will receive a 7.1% payment increase.</p> <p>Over time, under Medicare's prior payment system, beneficiaries' share of total outpatient payments grew to 50%. HOPD-PPS slowly reduces the beneficiary's copayment for these services. Copayments will be frozen at 20% of the national median charge for the service in 1996, updated to 1999. Over time, as PPS amounts rise, the frozen beneficiary copayments will decline as a share of the total payment until the beneficiary share is 20% of the Medicare fee schedule amount. A beneficiary copayment amount for a procedure is</p>		

Provider/service	General payment policy	General update policy	Most recent update
	limited to the inpatient deductible amount established for that year. Balance billing is prohibited.		

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

Provider/service	General payment policy	General update policy	Most recent update
Rural Health Clinics (RHCs) and Federally Qualified Health Center (FQHCs) services	RHCs and FQHCs are paid on the basis of an all-inclusive rate for each beneficiary visit for covered services. An interim payment is made to the RHC or FQHC based on estimates of allowable costs and number of visits; a reconciliation is made at the end of the year based on actual costs and visits. Per-visit payment limits are established for all RHCs (other than those in hospitals with fewer than 50 beds) and FQHCs. Assignment is mandatory; no deductible applies for FQHC services.	Payment limits are updated on January 1 of each year by the Medicare economic index (MEI) which measures inflation for certain medical services.	For CY2006 , the RHC upper payment limit is \$72.76 (compared to \$70.78 in 2005), the urban FQHC limit is \$112.96 (compared to \$109.88 in 2005), and the rural FQHC limit is \$97.13 (compared to \$94.48 in 2005).

14. Comprehensive Outpatient Rehabilitation Facility (CORF)

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

15. Part B Drugs/Vaccines Covered Incident to a Physician's Visit

Provider/service	General payment policy	General update policy	Most recent update
Drugs/vaccines. Medicare covers approximately 450 outpatient drugs and biologicals under the Part B program that are authorized by statute, including those: (1) that are covered if they are usually not self-administered and are provided incident to a physician's services; (2) those that are necessary for the effective use of covered DME; (3) certain self-	Drug products, except for pneumococcal, influenza, and hepatitis B vaccines, those associated with certain renal dialysis services, blood products and clotting factors and radiopharmaceuticals, are paid using the average sales price (ASP) methodology. Alternatively, beginning in 2006, payment may be made through the competitive acquisition program which is currently under development. Medicare's payment under the ASP methodology equals 106% of the applicable price for a multiple source drug or single source drug subject to beneficiary deductible and coinsurance amounts. Regular Part B	The ASP is updated quarterly by the Secretary. Widely available market prices are audited. Payments under the ASP method will be lowered if the ASP exceeds the widely available market price or average manufacturer price by a specified percentage (5% in 2006, determined by the Secretary in subsequent years). Where the percentage is exceeded, the Secretary will adjust the payment amount; in such cases, the payment would equal the lesser of the widely available market price or 103% of the average manufacturer price.	No specific provision.

Provider/service	General payment policy	General update policy	Most recent update
administered oral cancer and anti-nausea drugs (those with injectable equivalents); (4) erythropoietin (used to treat anemia); (5) immunosuppressive drugs after covered Medicare organ transplants; (6) hemophilia clotting factors; and (7) vaccines for influenza, pneumonia, and hepatitis B.	cost-sharing applies, except for pneumococcal and influenza virus vaccines. Assignment is mandatory.		

16. Blood

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

17. Partial Hospitalization Services Connected to Treatment of Mental Illness

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

18. Ambulance Services

Provider/service	General payment policy	General update policy	Most recent update
Ambulance services	<p>Medicare pays for ambulance services on the basis of a national fee schedule which is being phased in over a transition period. Prior to July 2004, a gradually increasing portion of the payment was based on the fee schedule and a decreasing portion on the former payment methodology (costs or charges). MMA established a new methodology beginning July 2004 with payments through 2009 equal to the greater of the national fee schedule or a blend of the national and regional fee schedule amounts. For July through December 2004, the blend was 20% of the national fee schedule rates and 80% of the regional rates. The portion of the blend based on national rates increases each year. In CY2010 and subsequently, the payments in all areas will be based on the national fee schedule amount.</p> <p>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);</p>	The fee schedule amounts are updated each year by the CPI-U. MMA provided an additional 2% payment increase for rural ambulance services and 1% payment increase for urban ambulance services for July 1, 2004-December 31, 2006.	The update for 2006 is 2.5% (compared to 3.3% in 2005). Other MMA changes will change the applicable rate.

Provider/service	General payment policy	General update policy	Most recent update
	<p>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).</p> <p>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. MMA establishes a 25% bonus on the mileage rate for trips of 51 miles and more from July 2004-December 2008. Regular Part B cost-sharing applies. Assignment is mandatory.</p>		

Parts A and B

1. Home Health

Provider/service	General payment policy	General update policy	Most recent update
Home health services	<p>Home health agencies (HHAs) are paid under a prospective payment system that began with FY2001. Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, and aide visits and medical supplies. Durable medical equipment is not included in the HH PPS.</p> <p>The base payment amount is adjusted for: (1) differences in area wages using the hospital wage index; (2) differences in the care needs of patients (case mix) using “home health resource groups” (HHRGs); (3) outlier visits (for the extraordinarily costly patients); (4) a significant change in a beneficiary’s condition (SCIC) when the care needs of a beneficiary increase substantially; (5) a partial episode for when a beneficiary transfers from one HHA to another during a 60-day episode; (6) budget neutrality; and (7) a low utilization payment adjustment (LUPA) for beneficiaries who receive four or fewer visits. There is not a distinction between</p>	<p>The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket index. This index measures changes in the costs of goods and services purchased by HHAs.</p> <p>The Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESA) of 1999 and BIPA made the following updates:</p> <p>FY2001 = MB FY2002 = MB - 1.1 FY2003 = MB - 1.1 FY2004 = MB - 0.8</p> <p>The MMA changed the update cycle for HHA from a federal fiscal year basis to a calendar year basis with the following updates:</p> <p>CY2004 (last three quarters only) = MB - 0.8 CY2005 = MB - 0.8</p>	<p>Because DRA eliminated the update for CY2006, the increase for CY2006 is 0. For CY2005 the update for home health was 2.3%.</p> <p>MMA provided a temporary 5% increase in payments for HHAs serving rural beneficiaries until March 31, 2005. DRA extended the payments for rural home health episodes or visits beginning on or after January 1, 2006 and before January 1, 2007.</p>

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Provider/service	General payment policy	General update policy	Most recent update
	<p>urban and rural base payment amounts.</p> <p>The HHRG applicable to a beneficiary is determined following an assessment of the patient's condition and care needs using the Outcome and Assessment Information Set (OASIS). After the assessment a beneficiary is categorized in one of 80 HHRGs that reflect the beneficiary's clinical severity, functional status, and service requirements.</p> <p>HHAs are paid 60% of the case-mix and wage-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.</p>	<p>CY2006 = MB - 0.8 CY2007 = MB</p> <p>DRA eliminated the update for home health payments for CY2006.</p>	

2. End-Stage Renal Disease

Provider/service	General payment policy	General update policy	Most recent update
End-stage renal disease	<p>Dialysis services are offered in three outpatient settings: hospital-based facilities, independent facilities, and the patient's home. There are two methods for payment. Under Method I, facilities are paid a prospectively set amount, known as the composite rate, for each dialysis session, regardless of whether services are provided at the facility or in the patient's home. The composite rate is derived from audited cost data and adjusted for the national proportion of patients dialyzing at home versus in a facility, and for area wage differences. Adjustments are made to the composite rate for hospital-based dialysis facilities to reflect higher overhead costs. Beneficiaries electing home dialysis may choose not to be associated with a facility and may make independent arrangements with a supplier for equipment, supplies, and support services. Payment to these suppliers, known as Method II, is made on the basis of reasonable charges, limited to 100% of the median hospital composite rate, except for patients on continuous cycling peritoneal dialysis, when the limit is 130% of the median hospital composite rate. Assignment is mandatory; regular Part B cost-sharing applies.</p>	<p>The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services furnished either at a facility or in a patient's home, for services furnished beginning on January 1, 2005. The basic case-mix adjusted system has two components: (1) the composite rate, which covers services, including dialysis; and (2) a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General Reports.</p> <p>The Secretary is required to update the basic case-mix adjusted payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate.</p>	<p>The DRA increased the composite rate component of the basic case-mix adjusted system for services beginning January 1, 2006 by 1.6%.</p> <p>For 2006, the base composite rate is \$130.40 for independent ESRD facilities and \$134.53 for hospital-based ESRD facilities. The total drug add-on adjustment, with inflation, is 14.5%.</p>

Provider/service	General payment policy	General update policy	Most recent update
	<p>MMA provides for update to the composite rate beginning January 1, 2005. Beginning April 1, 2005 the composite rate will be case-mixed adjusted, budget neutrally.</p> <p>Kidney transplantation services, to the extent they are inpatient hospital services, are subject to the PPS. However, kidney acquisition costs are paid on a reasonable cost basis.</p>		

Part C

1. Managed Care Organizations

Provider/service	General payment policy	General update policy	Most recent update
(a) Medicare advantage contracts	<p>In general, Medicare makes a monthly payment in advance to participating Medicare Advantage (MA) health plans for each enrolled beneficiary in a payment area. In exchange, the plans agree to furnish all Medicare-covered items and services to each enrollee.</p> <p>Beginning in 2005, payments to local MA plans are updated by the highest of the minimum percentage increase or, in years in which the Secretary specifies (but not</p>	<p>The MA rates are recalculated annually by the method described under “General Payment Policy.”</p> <p>Beginning in 2005, payments to local plans are annually updated by the greater of (1) a 2% increase over the prior year’s rate, (2) by the growth in the national growth percentage increases, or (3) in years as specified by the Secretary, 100% of FFS. The national growth percentage is equal to the projected increase in Medicare</p>	<p>For 2006, the Secretary did not recalculate FFS, so that 100% FFS was not used to determine 2006 MA local rates. The national growth percentage increase adjusted for prior years’ errors is 4.8% for 2006.</p>

Provider/service	General payment policy	General update policy	Most recent update
	<p>less than once every three years), 100% of FFS. The minimum percentage increase is the greater of a 2% increase over the previous year's payment rate or the previous year's payment increased by the national growth percentage.</p> <p>Beginning in 2006, the Secretary will determine local MA payment rates by comparing plan <i>bids</i> to a <i>benchmark</i>. Plans will submit <i>bids</i> representing their estimated premium for providing required Parts A and B benefits. The <i>benchmark</i> will be calculated, according to statute, by updating the previous year's payment in a local area by the minimum percentage increase or 100% of FFS, in years in which it is specified. If a plan's bid is less than the benchmark, its payment will equal its bid plus a rebate of 75% of the difference and the remaining 25% of difference will be retained by the federal government. If a plan's bid is equal to or above the benchmark, its payment will be the benchmark.</p> <p>Also beginning in 2006, the MA program will offer MA regional plans covering both in- and out-of-network required services. MA organizations will submit bids. The regional <i>benchmark</i>, unlike the local benchmark, includes two components; a</p>	<p>per capita expenditures.</p> <p>Furthermore, the national growth percentage is adjusted each year to correct for errors in prior years' rates. The MMA allows for adjustments beginning in 2004.</p> <p>The annual increase for regional plans and local plans in CCA areas will have both a statutory increase and a competitive increase. The statutory component is similar to the local update and the competitive component is based on a weighted average of plan bids. Congress made substantial changes to the Medicare+Choice program with the passage of the MMA. The act created the Medicare Advantage (MA) program which replaced the M+C program and introduced several enhancements designed to increase the availability of private plans for Medicare beneficiaries. In addition to the immediate payment increases to plans, beginning in 2006 the MA program will change the payment structure and introduce regional plans that operate like Preferred Provider Organizations. Additionally, in 2006 beneficiaries will have access to a drug plan whether they are in FFS Medicare or enrolled in managed care. Finally, beginning in 2010 a limited number of geographic areas will</p>	

Provider/service	General payment policy	General update policy	Most recent update
	<p>statutorily determined increase, and a weighted average of plan bids. Rebates for regional plans will be similar to rebates for local plans.</p> <p>Additional financial incentives will be provided for regional plans. A stabilization fund, with initial funding of \$10 billion in 2007, will provide incentives for plans to enter into and to remain in the MA program. Additional amounts may be added to the fund. The stabilization fund will be available through December 2013. For 2006 and 2007, Medicare will share risk with MA regional plans if plan costs fall above or below a statutorily specified risk corridor. Finally, there will be \$25 million available beginning in 2006 (with an increased amount each year) for additional payments to certain hospitals in regional areas that demonstrate that they have high costs.</p> <p>Also beginning in 2006, at least one plan offered by an MA organization is required to be an MA-PD plan, one that offers Part D prescription drug coverage. MA organizations offering prescription drug coverage will receive a direct subsidy for each enrollee in their MA-PD plan, equal to the plan's risk adjusted standardized bid amount (reduced by the base beneficiary</p>	<p>be selected to examine enhanced competition between local MA plans and competition between private plans and FFS Medicare.</p>	

Provider/service	General payment policy	General update policy	Most recent update
	<p>premium). The plan will also receive the reinsurance payment amount for the federal share. Finally, an MA-PD plan will receive reimbursement for the premium and cost-sharing reduction for its qualifying low-income enrollees.</p> <p>A six-year program will begin in 2010 to examine comparative cost adjustment (CCA) in designated CCA areas. Payments to local MA plans in CCA areas will, in part, be based on competitive bids (similar to payments for regional MA plans), and Part B premiums for individuals enrolled in traditional Medicare may be adjusted, either up or down. This program will be phased-in and there is also a 5% annual limit on the adjustment, so that the amount of the adjustment to the beneficiary's premium for a year can not exceed 5% of the amount of the monthly Part B premium, in non-CCA areas.</p> <p>Most recently, the DRA made changes to the calculation of the statutory benchmark. In 2007, MA payments will be calculated by updating the previous year's payment by the minimum percentage increase or if the Secretary rebases FFS, 100% of FFS. Beginning in 2007, as specified under current law, benchmarks will continue to</p>		

Provider/service	General payment policy	General update policy	Most recent update
	<p>be updated by the minimum percentage increase with corrections prior year's errors after 2004. In addition there will be two new adjustments made in calculating the benchmark: (1) exclude any national adjustment factors for coding intensity, and (2) exclude budget neutrality in risk adjustment (will actually be phased out over four years). After 2007, if the Secretary does not rebase rates in a given year, the MA benchmarks would be the previous year's benchmark (prior to the application of the phase-out percentage for risk adjustment) increased by the national per capita MA growth percentage with adjustments for prior year errors beginning in 2004. If the Secretary rebases rates in a given year, then the benchmark would be equal to the greater of the minimum percentage increase or 100% FFS.</p> <p>For purposes of calculating the phase-out of budget neutrality in risk adjustment, the Secretary would be required to conduct a study of the difference between treatment and coding patterns between MA plans and providers under Parts A and B of Medicare using data starting in 2004. The findings would be incorporated into calculations of MA benchmarks, but only in 2008, 2009, and 2010.</p>		

Provider/service	General payment policy	General update policy	Most recent update
	Eliminating budget neutrality for risk adjustment would not occur in any year if it would increase payments.		
(b) Cost contracts	Medicare pays cost contract health maintenance organizations (HMOs) and competitive medical plans (CMPs) the actual costs they incur for furnishing Medicare-covered services (less the estimated value of required Medicare cost-sharing), subject to a test of "reasonableness." Interim payment is made to the HMO/CMP on a monthly per capita basis; final payment reconciles interim payments to actual costs.	No specific update. Cost-based HMOs are paid 100% of their actual costs.	No specific update. (However MMA extends or renews reasonable cost contracts indefinitely. Beginning January 1, 2008, cost contracts may not be extended or renewed in a service area if, during the entire previous year, the service area had two or more MA regional plans or two or more MA local plans meeting the following minimum enrollment requirements: (1) at least 5,000 enrollees for the portion of the area that is within a metropolitan statistical area having more than 250,000 people and counties contiguous to such an area, and (2) at least 1,500 enrollees for any other portion of such area.

CRS Reports for Additional Information

CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, by Jennifer O’Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer L. Boulanger, and Paulette C. Morgan.

CRS Report RL32005, *Medicare Fee-for-Service Modifications and Medicaid Provisions of H.R. 1 as Enacted*, by Sibyl Tilson, Jennifer L. Boulanger, Jean Hearne, C. Stephen Redhead, Evelyn P. Baumrucker, Julie Stone, Bernadette Fernandez, and Karen Tritz.

CRS Report RL31419, *Medicare: Payments for Covered Prescription Drugs*, by Jennifer O’Sullivan.

CRS Report RL31199, *Medicare: Payments to Physicians*, by Jennifer O’Sullivan.

CRS Report RL30702, *Medicare+Choice*, by Hinda Chaikind and Paulette C. Morgan.

CRS Report RL32618, *Medicare Advantage Payments*, by Hinda Chaikind and Paulette C. Morgan.

CRS Report RL31341, *Medicare’s Durable Medical Equipment and Prosthetics and Orthotics Benefit*, by Heidi G. Yacker and Jennifer L. Boulanger.

CRS Report RS21814, *Medicare Home Health—Benefits and Payments*, by Jennifer L. Boulanger.

CRS Report RS21465, *Medicare’s Skilled Nursing Facility Payment*, by Jennifer L. Boulanger.

CRS Report RL32640, *Medicare Payment Issues Affecting Inpatient Rehabilitation Facilities (IRFs)*, by Sibyl Tilson.