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The A B C's *[and D]* of Medicare

Healthcare payment seems to be developing a language all its own these days. Newer entries in the lexicon include MACRA, CJR and BPCI. PQRS and VM are current terms while SGR has joined the ranks of past payment methods. Because many of these payment models (past, present and future) combine –or differentiate – between the parts of the Medicare program, a review of Medicare basics is in order.

When the original Medicare program was signed into law in 1965, it included two programs – Hospital Insurance and Medical Insurance. In 2003, the Medicare Prescription Drug Improvement and Modernization Act (MMA) expanded the Medicare program. MMA added coverage offerings via plans administered by private payers. It also established an option for prescription drug coverage. The original programs and the two additions from the MMA are known as Part A, Part B, Part C and Part D respectively.

Part A: Hospital Insurance

One of the two original programs, Part A covers inpatient hospital care, skilled nursing care, hospice and, in some circumstances, home health care. Medicare payment to these facilities is based on a prospective payment system.

Part B: Medical Insurance

Part B is the other part of original Medicare. Part B covers professional services, outpatient care and some preventative services. Medicare Part B uses a Fee for Service (FFS) system to determine payments to physicians and other health care professionals who provide care to beneficiaries covered under this program.

Part C: Medicare Advantage (also known as MA)

Part C plans are offered by private payers under contract with Medicare. The plans are administered by the private payer and may include benefits not included in original Medicare. For example, many of these plans include prescription drug coverage. Payment rates and coverage policies vary depending upon the specific plan.

Part D: Prescription Drug Coverage

A supplement to original Medicare, Part D prescription drug coverage is available from insurance companies that have been approved by Medicare to offer this coverage to Medicare beneficiaries.

There have been signals that change was in the air. In its first iteration, Part A and Part B were separate programs administered by separate entities. Claims for Part A services were processed and paid by fiscal intermediaries and claims for Part B services were handled by carriers. CMS has since consolidated these functions. Medicare Administrative Contractors (MACs) now handle both Part A and Part B claims within their assigned jurisdictions. The Patient Protection and Affordable Care Act (ACA) initiated a shift from payments based on Fee for Service to Fee for Value.

The Sustainable Growth Rate (SGR) was a significant part of the calculation of the Medicare conversion factor (CF). The CF translates the values assigned to a specific procedure or service into dollars. The SGR set targets for Medicare Part B spending. When spending exceeded the targets, the formula resulted in decreases to the CF. One of SGR's many flaws was that it did not recognize how changes in Part B spending could result in savings in Part A.

Current quality and value programs for physician payments differentiate between Part B and Part C. For example, the payment adjustments under the Physician Quality Reporting System (PQRS) are 2% of an eligible professional's Part B payments. Value based Payment Modifier (VM) incentive and adjustments amounts are also based on Part B payments.

New payment methods are combining these plans that previously operated in silos. The Bundled Payment for Care Initiative Program (BPCI) includes four methods that offer varying combinations of Parts A and B. Under the Comprehensive Care for Joint Replacement (CJR) program, physicians and other professionals will continue to submit claims to and receive payment from Part B. However, the hospital in which the joint replacement procedure is performed will be held to a target that will include all Part and Part B costs from the admission through 90 days post discharge. Hospitals may seek collaborative agreements with physicians who provide care within in the episode. Such agreements may result in positive and/or negative risk sharing.

Looking ahead, at this point it is unclear whether the Resource Use (RU) component of the Merit-based Incentive Payment System (MIPS) within the Medicare Access and CHIP Reauthorization Act (MACRA) will include Part D spending. Further, for anesthesiology, it will be important that Resource Use metrics do not repeat the SGR's shortcoming; RU metrics will need to acknowledge how anesthesiologists can contribute to savings in the Part A program. Qualifying Alternative Payment Models (APMs) under MACRA may very well resemble some of the arrangements found in BPCI and CJR where Part A and B costs and savings are pooled.

An understanding of the fundamental characteristics of Parts A, B, C and D of the Medicare program will be important as the details for implementation of MACRA unfold.