2014

Medicare Explained

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Law & Business

2014 Medicare Explained

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Foreword

This book has been prepared for Medicare beneficiaries and others who need a relatively thorough explanation of the Medicare program with particular emphasis on services covered in institutional settings and services provided by physicians and suppliers.

Published annually, this book includes changes made by law and regulation amendments and by updates to program manuals issued by the Centers for Medicare and Medicaid Services (CMS). This edition includes changes issued during 2013 that affect Medicare beneficiaries and providers in 2014.

The 2014 highlights are as follows:

Medicare Part A (hospital insurance). For 2014, the inpatient hospital deductible will be $1,216 per each beneficiary "spell of illness," an increase from the $1,184 inpatient deductible in 2013. Patients are responsible for a coinsurance amount for each day after the 60th and through the 90th day per spell of illness, and in 2014 daily coinsurance amounts will be $304 for the 61st through 90th day of hospitalization. When Medicare patients use their lifetime reserve days in 2014, their coinsurance will be $608 per day. When Medicare patients are patients in skilled nursing facilities in 2014, their coinsurance will be $152 for the 21st through 100th day of skilled nursing facility care (see ¶ 221, ¶ 222, ¶ 242).

Medicare Part B (supplementary medical insurance). The Part B premium for 2014 will be $104.90, unless the Medicare beneficiary is subject to an income-adjusted premium. Income-adjusted premiums for 2014 are as follows: Individuals with modified adjusted gross income (MAGI) greater than $85,000 but less than or equal to $107,000 and couples with MAGI greater than $170,000 but less than or equal to $214,000 will pay a monthly premium of $146.90. Individuals with MAGI greater than $107,000 but less than or equal to $160,000 and couples with MAGI greater than $214,000 and less than or equal to $320,000 will pay a monthly premium of $209.80. Individuals with MAGI greater than $160,000 but less than or equal to $214,000 and couples with MAGI greater than $320,000 and less than or equal to $428,000 will pay a monthly premium of $272.70. Individuals with MAGI greater than $214,000 and couples with MAGI greater than $428,000 will pay a monthly premium of $335.70. The rates are modified slightly for beneficiaries who are married and lived with their spouse at any time during the taxable year but file a separate tax return from their spouse (see ¶ 320).

For 2014, the Part B deductible will remain at $147 (see ¶ 335).

Physician reimbursement. In 2013, CMS began making a separate payment for transitional care management services furnished to a beneficiary making the transition from a facility stay back to the community. CMS continued to emphasize advanced primary care by establishing a separate payment for ongoing care management and continuous assessment that occurs outside of a face-to-face visit with a patient, beginning in calendar year (CY) 2015. Medicare will make this payment for non-face-to-face chronic care management services furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline (see ¶ 860).

Inpatient hospital reimbursement. To reduce the use of observation status, CMS implemented the "two midnight" rule. Under the "two midnight" rule, effective for admissions on or after October 1, 2013, if a physician expects a beneficiary's surgical procedure, diagnostic test, or other treatment to require a stay in the hospital lasting at least two midnights and admits the beneficiary to the hospital based on that expectation, it is presumed to be appropriate that the hospital receive Medicare Part A payment (see ¶ 810).

Outpatient servies. For CY 2014, CMS expanded the categories of related items and services packaged into a single payment for a primary service under the outpatient prospective payment system (OPPS) and finalized five new categories of supporting items and services to be included in payment for a primary service. It also replaced the five levels of outpatient clinic visit codes with a single code describing all clinic visits (see ¶ 874).

Medicare Part C (managed care plans). For 2012 and subsequent years, Medicare Advantage (MA) organizations must provide enrollees a monthly rebate equal to a specified percentage of their average per capita savings (if any). For 2012 and 2013, this percentage was based on a combination of the "rule of 75 percent" and the rules that set the percentage based on a plan's quality rating under a 5-star rating system; however, for 2014 and subsequent years, this percentage will be determined based only on the final applicable rebate percentage (see ¶ 407).

The special needs plan (SNP) program, which covers managed care plans for individuals with special needs, has been extended through plan year 2016 (¶ 400).

Medicare Part D (prescription drug plans). For 2014, beneficiaries in standard prescription drug plans (PDPs) will be subject to a $310 deductible. In 2014, beneficiaries in the coverage gap will continue to receive a 50 percent discount on brand-name drugs. PDPs also must pay another 2.5 percent, providing Part D beneficiaries with total coverage of 52.5 percent in the donut hole. Therefore, PDP beneficiaries will pay 47.5 percent of the costs for brand-name drugs in the donut hole. Also, PDP coverage of generic drugs in the coverage gap will increase to 21 to 28 percent in 2014 (see ¶ 510). The donut hole is gradually closing; by 2020, cost-sharing for both brand and generic prescription drugs will be the same during the donut hole as during the initial coverage period, i.e., beneficiaries will pay 25 percent of drug costs and PDPs will pay 75 percent (see ¶ 510).

For 2014, the national average monthly bid amount for a PDP will be $75.88, down from $79.64 in 2013. The 2014 base beneficiary premium will be $32.42, up from $31.17 in 2013. High-income beneficiaries will be subject to income-adjusted premiums for Part D, just as they will be for Part B. For 2014, the income-related monthly adjustment amount for a PDP premium will be $12.10 for an individual with MAGI greater that $85,000, but not more than $107,000; $31.10 for an individual with MAGI greater than $107,000, but not more than $160,000; $50.20 for an individual with MAGI greater than $160,000, but not more than $214,000; and $69.30 for an individual with MAGI greater than $214,000. In the case of a joint tax return, the MAGI dollar amounts are doubled (see ¶ 508).

Quality of care. A number of quality of care initiatives will continue to be implemented by CMS in fiscal year (FY) 2014, many of which will affect provider and facility reimbursement.

Under the 10th Scope of Work, which began August 1, 2011, and runs through July 31, 2014, quality improvement organizations (QIOs) are responsible for completing the requirements for the following aims: (1) beneficiary- and family-centered care; (2) improved individual patient safety, focused on health care–associated infections, pressure sores, physical restraints, nursing home systemic improvement, adverse drug events, and quality reporting and improvement; (3) integrated care for people who transition from health care entities; and (4) improve health for populations and communities through prevention. Beginning in 2013, QIOs must make available a new, informal, alternative dispute resolution process, called "immediate advocacy," for beneficiaries' oral complaints about quality of care (see ¶ 710).

Inpatient hospitals that do not submit required quality data on specific quality indicators to the Medicare program each year will have their applicable hospital market basket

percentage increase reduced by 2 percent. To receive the full market basket update for FY 2016, in FY 2014 hospitals must report on 57 quality measures, including measures for: perinatal care, readmissions, surgical complications, and health care–associated infections. Similarly, Medicare payments to hospitals can be reduced under the Hospital Readmissions Reduction Program, and hospitals can earn incentives under the Hospital Inpatient Value-Based Purchasing Program (see ¶ 810).

Providers of outpatient services that fail to report quality of care data on 24 quality measures will receive a 2.0 percent reduction to their annual market basket payment for CY 2014 (see ¶ 874).

Under the Physician Quality Reporting System, physicians report on measures groups created for specific conditions. For 2012, 2013, and 2014, PQRS incentive payments are 0.5 percent of the total estimated Medicare Part B physician fee schedule allowed charges for covered professional services furnished for the reporting period; starting with CY 2015, a negative adjustment will apply for failure to satisfactorily report (see ¶ 860).

Other Wolters Kluwer publications:

Further details on the topics covered in this book, together with the texts of pertinent laws, regulations, policy guidelines, court decisions, etc., may be found in Wolters Kluwer's MEDICARE AND MEDICAID GUIDE. The GUIDE is available as a six-volume, loose-leaf print product as well as electronically on the Internet. Other electronic databases, including the full text of the CMS Program Manuals and the codes and complete descriptions contained in the Physician Fee Schedule, are offered as part of Wolters Kluwer's electronic Health Law Library. Wolters Kluwer also has an easy-to-read electronic reporter specializing in Part B issues entitled the PHYSICIANS' MEDICARE GUIDE. In print and electronic form, Wolters Kluwer also offers a comprehensive guide to the landmark health care reform legislation passed in 2010, entitled CCH'S LAW, EXPLANATION AND ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: INCLUDING RECONCILIATION ACT IMPACT, VOLUMES 1 AND 2.

Finally, Wolters Kluwer publishes the following related paperback books:

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A note about the citations in the text:

Throughout the text, statements are documented, when possible, by citations to the law, regulations, and program manuals issued by the federal government. In the interests of simplicity and conservation of space, citations generally have been made only to the highest authority available for the statement in the text, although, when appropriate, multiple citations (i.e., citations both to a law provision and its implementing regulation) are included. In some instances, when there is no clear ranking of authorities, only the most widely available source is cited.

January 2014

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