ALTARUM
HEALTHCARE VALUE HUB

Glossary: Medicare Reimbursement

As policymakers and payers attempt to combat high healthcare prices, one common approach is to benchmark prices against the rates set by the Centers for Medicare and Medicaid Services (CMS) for Medicare beneficiaries. As our accompanying issue brief shows, there are advantages and disadvantages of using Medicare as a benchmark. Best practices might entail starting with Medicare's approach while addressing some shortcomings.

Term	Abbre-viation	Definition
Ambulatory Payment Classifications	APCs	Medicare procedure or service classification system used by hospitals to seek reimbursement for outpatient care based on predetermined rates per service. Most services paid under Medicare Outpatient Prospective Payment Systems (OPPS) are reimbursed under APCs.
Benchmark Price		A rate used as a reference point for reimbursement rates. For example, setting rates at 110% of the Medicare benchmark price.
Consolidated Hospital Market		Hospital systems that wield market power through vertical mergers. In nine out of ten metropolitan areas, the provider market is considered highly concentrated, thereby limiting competition. A common measure of market concentration known as the Herfindahl-Hirschman Index (HHI). A higher HHI value signifies a more highly concentrated market.
Common Procedural Technology	CPT	Billing codes assigned to every task and service a medical practitioner may provide to a patient including medical, surgical and diagnostic services. CPT codes were developed by the AMA. Identical to level 1 HCPCS codes.
Diagnosis-Related Groups	DRGs	A patient classification system that standardizes prospective payment to hospitals and encourages cost containment initiatives. In general, a DRG payment covers all charges associated with an inpatient stay from the time of admission to discharge.
Fee-for-Service	FFS	A payment model in which providers are paid for every unit of service delivered without considerations of quality, outcomes or efficiency.
Healthcare Common Procedure Coding System	HCPCS	A standardized code system used to report hospital services and physician services that participate in the OPPS, for reimbursement by CMS to providers for outpatient services. Level 1 HCPCS codes are identical to CPT. Level 2 HCPCS codes are designed to represent non-physician services (e.g. ambulance rides, wheelchairs or durable medical equipment).
Hospital Rate Setting		Sets limits on the rates or budgets of hospitals. Some rate setting programs use a formula-based approach, some review rates or budgets of hospitals individually and some use a mix of these two approaches.

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Inpatient Prospective Payment System	IPPS	A payment system created to reimburse acute care hospital inpatient stays under Medicare Part A (Hospital Insurance), based on prospectively-set rates. Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.
Hospital Margin		The difference between total net revenue and total expenses divided by total net revenue; also known as the payment-to-cost ratio.
Medicare Payment Advisory Commission	MedPAC	MedPAC is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program.
Outpatient Prospective Payment System	OPPS	Pays hospitals based on predetermined rates per service or ambulatory payment classifications (APCs). APCs are associated with one or more Healthcare Common Procedure Coding System codes (HCPCS codes) which are updated annually.
Payment-to-Cost Ratio		The ratio of total payments to total charges.
Relative Value Scale Update Committee or Relative Value Update Committee	RUC	The RUC is a unique multispecialty committee, developed by the American Medical Association (AMA), dedicated to describing the resources required to provide physician services which the Centers for Medicare & Medicaid Services considers in developing Relative Value Units (RVUs). In the past, CMS accepted the RUC recommendations 90% of the time. The agency accepted 71% of RUC RVU recommendations for 2019.
Relative Value Unit	RVU	A measure of value used in the United States Medicare reimbursement formula for physician services; measures the resources used to provide a given service including the physician's work, the expenses of the physician's practice, and professional liability insurance. RVUs are a part of the resource-based relative value scale (RBRVS).
Resource-Based Relative Value Scale	RBRVS	A physician payment system used to determine how much providers should be paid.
Site-Neutral Payment		A Medicare payment policy that pays the same amount for outpatient services provided at independent offices, ambulatory clinics or hospital-affiliated facilities.
Upcoding		A practice whereby hospitals and other providers use billing codes or DRGs that reflect a more severe illness or expensive treatment in order to seek a larger reimbursement from Medicare.

For background and a discussion of using Medicare rates as a benchmark, please see *Medicare Rates as a Benchmark: Too Much, Too Little or Just Right?* Research Brief No. 40 (February 2020).