Appendix D: Medicare Reimbursement Methodology

As discussed in the introduction to this Benchmarking Study, WDH conducted an analysis of reimbursement information for each Medicaid service area. Appendix D describes Medicare's reimbursement methodologies for the service areas with a comparable rate used in this study.

Figure D.1: Medicare Methodology by Service Area

Service Area	Medicare Methodology
Ambulance	Prospective Fee Schedule
Ambulatory Surgery Center (ASC)	Ambulatory Payment Classification (APC)
Behavioral Health	Physician Fee Schedule (RBRVS)
Dental	N/A
Developmental Center	Physician Fee Schedule (RBRVS)
Durable Medical Equipment, Prosthetic, Orthotic and Supply (DMEPOS)	DMEPOS Fee Schedule
End Stage Renal Disease (ESRD)	Prospective Payment System
Federally Qualified Health Center (FQHC)	Prospective Payment System
Home Health	Prospective Payment System
Hospice	Prospective Payment System: Daily Rate
Hospital – Inpatient	CMS Acute Inpatient PPS (IPPS)
Hospital – Outpatient	Outpatient Prospective Payment System (OPPS)
Intermediate Care Facility	N/A
Laboratory	Fee Schedule
Nursing Facility	Prospective Payment System: Per Diem Rate
Program of All-Inclusive Care for the Elderly (PACE)	Per Member Per Month Capitated Rate
Public Health, Federal (Tribal Facilities)	Prospective Payment System
Physician and other Practitioners	Physician Fee Schedule (RBRVS)
Prescription Drugs	Average Sale Price (ASP)
Psychiatric Residential Treatment Facility (PRTF)	N/A
Rural Health Clinic (RHC)	All-inclusive Rate Per Visit with Exceptions
School Based Services	N/A

Service Area	Medicare Methodology
Vision	Physician Fee Schedule
Waivers	N/A

Ambulance

Medicare uses a prospective fee schedule methodology to pay for ambulance services. The fee schedule payment for these services includes a base rate payment, a separate payment for mileage to the nearest appropriate facility, and all medically necessary items and services related to the transport.[1] The base rate payment is a combination of the base rate – the relative value unit multiplied by the ambulance conversion factor – multiplied by geographic factors.[2] Under the prospective fee schedule, Medicare pays for each "loaded mile."[3] There are three mileage payment rates: a rate for fixed-wing aircraft services, a rate for rotary wing aircraft services, and a rate for all levels of ground transportation. CMS updates the ground and air ambulance fee schedule annually according to an inflation factor established by law. The inflation factor is based on the CPI for all urban consumers for the 12-month period ending with June of the previous year. The Ambulance Inflation Factor (AIF) was one-point one percent (1.1%) for CY 2018, two-point three percent (2.3%) for CY 2019, and zero-point nine percent (0.9%) for CY 2020.[4]

Section 50203 of the Bipartisan Budget Act of 2018 extends payment provisions of previous legislation affecting ambulance fee schedule amounts, which include:

- *The Medicare and CHIP Reauthorization Act (MACRA) of 2015, Protecting Access to Medicare Act of 2014;*
- *The Pathway for SGR Reform Act of 2013;*
- *The American Taxpayer Relief Act of 2012*
- *The Middle Class Tax Relief and Job Creation Act of 2012;*
- *The Temporary Payroll Tax Cut Continuation Act of 2011;*
- *The Medicare and Medicaid Extenders Act of 2010;*
- *The Patient Protections and Affordable Care Act of 2010 (ACA);* and
- The *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).*

[1] Centers for Medicare and Medicare Services, "*Ambulance Fee Schedule and Medicare Transports*," (July 2019). Retrieved on October 16, 2019., Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf
[2] MedPAC, "*Ambulance Services Payment System*," (October 2020). Retrieved on December 9, 2020., Available online: http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_ambulance_final_sec.pdf?sfvrsn=0
[3] A loaded mile is a mile during which a Medicare beneficiary is transported in an ambulance.
[4] Centers for Medicare and Medicaid Services, "*Medicare Claims Processing Manual,"* (October 2019). Retrieved on December 9, 2020 Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4407CP.pdf

Section 50203(a)(1) of the Bipartisan Budget Act of 2018 extends the increase in the ambulance fee schedule amounts for covered ambulance transports which originate in rural areas by three percent (3%) and in urban areas by two percent (2%) (urban and rural areas as defined by the ZIP Code of the point of pickup) through December 31, 2022.

Section 50203(a)(2) of the Bipartisan Budget Act of 2018 also extends the provision relating to payment for ground ambulance services that increased the base rate for transports originating in an area within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus). The extension will continue through December 31, 2022 and the increase will continue to be twenty-two-point six percent (22.6%).[5]

Section 53108 of the Bipartisan Budget Act of 2018 increases the reduction in AFS payments from ten percent (10%) to twenty-three percent (23%) effective October 1, 2018. This reduction only applies to non-emergency basic life support services involving transport of individuals with end-stage renal disease (ESRD) for renal dialysis services.[5]

To help combat the COVID-19 public health emergency, CMS has authorized ambulance transport between a wider variety of locations as long as the ambulance is equipped to treat a patient's condition in accordance with state and local laws. Medicare will now cover transport to COVID-19 testing facilities, alternative hospital sites, urgent care facilities, and physician offices in addition to other newly permitted locations.[2]

Ambulatory Surgical Centers

The definition of ambulatory surgical center (ASC) is "a facility which provides surgical treatment to patients not requiring hospitalization and is not part of a hospital or an office of private physicians, dentists, or podiatrists."[6] Services provided by freestanding ambulatory surgical centers are those that do not require overnight inpatient hospital care. Wyoming's Medicaid ASC services encompass all surgical procedures covered by Medicare as well as additional surgical procedures that Wyoming Medicaid approves under the provision of outpatient services.

Effective January 1, 2008, CMS transitioned to a revised ASC payment system using the Outpatient Prospective Payment System (OPPS) relative payment weights as a guide.[7] In its annual updates to the ASC payment system, CMS sets relative payment weights equal to

[5] Centers for Medicare and Medicaid Services, *"Ambulance Fee Schedule Public Use Files".* (December 2019).Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.html
[6] Wyoming Department of Health. *Ambulatory Surgical Center*," (February 2019). Available online: https://health.wyo.gov/aging/hls/facility-types/ambulatory-surgical-center-wyoming-licensure-information/
[7] Centers for Medicare and Medicaid Services. "*Ambulatory Surgical Center Fee Schedule: Payment System Series*," (March 2020). Available online: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/ambsurgctrfeepymtfctsht508-09.pdf

OPPS relative payment weights for the same services and then scales the ASC weights to maintain budget neutrality.[8]

Up until 2018, the ASC conversion factor was annually adjusted by removing effects of change in wage index values for the upcoming year as compared to the current year. This was done by subtracting the MFP adjustment from the Consumer Price Index for all urban consumers (CPI-U) in order to get the MFP-adjusted CPI-I update factor.[9] As of November 2, 2018, CMS updated the ASC payment rates using the hospital market basket rather than the CPI-U for CY 2019 through CY 2023.[10] By using the hospital market basket, CMS updated ASC rates for CY 2020 by two-point six percent (2.6%) based on the basket increase of three-point zero percent (3.0%) minus zero-point four percent (0.4%) for the MFP adjustment.

ASCs will receive payment for the lesser of the actual charge or the ASC payment rate for each procedure or service provided. The standard payment rate for ASC-covered surgical procedures is calculated by multiplying the ASC conversion factor by the ASC relative weight for each separately payable procedure or service provided.[7]

Behavioral Health

Medicare pays for mental health services provided by physicians, clinical psychologists, or clinical social workers according to the Medicare physician fee schedule. Psychiatrists and clinical psychologists are paid at one hundred percent (100%) of the amount that a physician is paid under the Medicare physician fee schedule, clinical social workers are paid at seventy-five percent (75%) of the amount that a clinical psychologist is paid. Clinical nurse specialists, nurse practitioners and physician assistants are paid at ninety percent (90%) of the amount that a physician is paid. Payment for assistant-at-surgery services for clinical nurse specialists, nurse practitioners and physician assistants are at approximately sixteen percent (16%) of the amount a physician is paid under the Medicare physician fee schedule.[11,12]

Medicare also pays for substance abuse services provided in inpatient and outpatient settings. Medicare Part A pays for inpatient treatment and Medicare Part B pays for outpatient treatment and partial hospitalization. Reimbursement for these services depends on the type of provider

[8] Centers for Medicare and Medicaid Services, "Ambulatory Surgical Center Payment – Notice of Final Rulemaking with Comment" (2020). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC
[9] Centers for Medicare and Medicaid Services, "*Federal Register Vol. 81 No. 219,"* (November 2016) Available online: https://www.govinfo.gov/content/pkg/FR-2016-11-14/pdf/2016-26515.pdf
[10] Centers for Medicare and Medicaid, "Hospital Outpatient Prospective Payment – Notice of Final Rulemaking" (2020). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC
[11] Please see the Physician and Other Practitioner section for more information on the Medicare Physician Fee Schedule.
[12] Centers for Medicare and Medicaid Services, *Medicare, and Your Mental Health Benefits*. (March 2020) Available online: https://www.medicare.gov/Pubs/pdf/11358-Medicare-Mental-Health-Getting-Started.pdf

that provides the service.[13,14,15] Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients (SUPPORT) Act established a new benefit category for Opioid Use Disorder (OUD) services furnished by Opioid Treatment Programs (OTPs), effective January 1, 2020.[16]

Dental

In general, Medicare does not reimburse dental services in conjunction with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth.[17] Medicare only covers dental services that are an essential part of a covered procedure, such as a jaw reconstruction due to an accidental injury, or dental services done in preparation for services involving the jaw. In other cases, Medicare will pay for oral examinations but not treatment for identified problems. Oral examinations are covered under Medicare Part A if performed by a dentist that is part of the hospital's staff or under Medicare Part B if performed by a physician.

Developmental Center

Medicare covers most of the services offered by Developmental Centers, and reimbursement is based on the physician fee schedule using the Resource-Based Relative Value Scale (RBRVS) system.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Medicare pays for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) with the exception of oxygen and oxygen equipment, using the DMEPOS fee schedule.[18] Medicare used to have a national competitive bidding program for various DMEPOS services, but all contracts expired on December 31, 2018.[19] As of January 1, 2019, there will be a temporary gap in this program until December 31, 2020.[20]

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[13] Centers for Medicare and Medicaid Services, "*Mental Health Care (Inpatient),"* Available online: https://www.medicare.gov/coverage/inpatient-mental-health-care.html

[14] Centers for Medicare and Medicaid Services, *"Mental Health Care (Outpatient),"* Available online: https://www.medicare.gov/coverage/outpatient-mental-health-care.html

[15] Centers for Medicare and Medicaid Services, *"Medicare Coverage of Substance Abuse Services,"* (May 2019). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf

[16] Centers for Medicare and Medicaid Services, "Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2020" (November 2019). Retrieved on December 9, 2020. Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F

[17] Centers for Medicare and Medicaid Services, "*Medicare Dental Coverage,*" (March 2014). Retrieved on October 28, 2019. Available online: http://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html

[18] Centers for Medicare and Medicaid Services, "*DMEPOS Fee Schedule*," (February 2019). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

[19] Centers for Medicare and Medicaid Services, "*DMEPOS Competitive Bidding*," (September 2019). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html

[20] Centers for Medicare and Medicaid Services, "*DMEPOS Temporary Gap Period*," (October 2018). Available online: https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/DMEPOS-Temporary-Gap-Period-Fact-Sheet.pdf

DMEPOS Fee Schedule

Medicare limits payments based on its fee schedule to eighty percent (80%) of the lower of either the actual charge for the item, or the fee schedule amount calculated for the item, less any unmet deductible payments.[21] CMS releases a new payment amounts semi-annually that implements fee schedule amounts for new codes and revises fee schedule amounts that were calculated in error for existing codes. CMS also updates the fee schedule quarterly.

Effective January 2016, Medicare released a quarterly rural ZIP Code file to determine if codes qualify for rural or non-rural fee schedule payments for applicable codes.[19] In accordance with Sections 1834(a) (14) of the Act, a point-nine percent (0.9%) update factor has been applied to the DMEPOS fee schedule based on the percentage increase in the CPI-U for Calendar Year 2020. The MFP adjustment of point seven percent (0.7%) to the one-point six percent (1.6%) increase in the CPI-U results in the point nine percent (0.9%) net increase for the update factor.[22]

DMEPOS Competitive Bidding Program

Section 302 of the *Medicare Modernization Act of 2003 (MMA*) established requirements for a competitive bidding program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to provide certain items in competitive bidding areas, and CMS awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services.

DMEPOS Competitive Bidding Temporary Gap

Throughout the temporary gap, any Medicare enrolled DMEPOS supplier may provide DMEPOS products and services to people with Medicare.[21] However, suppliers must continue to provide Capped Rental items (like wheelchairs and hospital beds) as well as oxygen and oxygen equipment through the remainder of their rental periods. An exception to these requirements is if people with Medicare travel or permanently move outside of the supplier's normal service area. For all other DMEPOS products, Medicare recipients may need to switch suppliers if their current supplier is not willing to continue providing items.

[21] Centers for Medicare and Medicaid Services, "*Durable Medical Equipment, Prosthetics/Orthotics & Supplies Fee Schedul*e,". Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html?redirect=/dmeposfeesched/

[22] Centers for Medicare and Medicaid Services, *"Calendar Year (CY) 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule,"* (January 2020). Available online: https://www.cms.gov/files/document/mm11570.pdf

End Stage Renal Disease

Medicare is the primary payer of end stage renal disease (ESRD) services and payment is based on a bundled Prospective Payment System (PPS) consolidated billing process. The *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA*) amended section 1881(b) of the Social Security Act to require the implementation of an ESRD bundled payment system with the effective date of January 1, 2011. The ESRD consolidated PPS provides a case-mix adjusted single payment to ESRD facilities for renal dialysis services and other items and services (for example, supplies and equipment used to administer dialysis, drugs, biologicals, laboratory tests, and support services) related to home dialysis. Consolidated billing requirements confer the ESRD facility the payment responsibility for all of the renal dialysis services that their ESRD patients receive, including those services provided by other suppliers and providers, delivered in both an ESRD facility as well as in a beneficiary's home.[23]

The ESRD PPS includes patient-level adjustments (also known as the case-mix adjustments), facility-level adjustments, and training adjustments, as well as an outlier payment. Under the ESRD PPS, the beneficiary co-insurance amount is twenty percent (20%) of the total ESRD PPS payment, after the deductible. The ESRD PPS base rate is adjusted for characteristics of adult and pediatric patients, which accounts for case-mix variability. The adult case-mix adjusters can include, but are not limited to: age, body surface area, and body mass index (BMI). In addition, the ESRD PPS includes adult adjustments for six co-morbidity categories, as well as the onset of renal dialysis. Pediatric patient-level adjusters consist of combinations of two age categories and two dialysis modalities.

There are two facility-level adjustments in the ESRD PPS:

- The first adjustment accounts for ESRD facilities with a low-volume of dialysis treatments.
- The second adjustment reflects urban and rural differences in area wage levels using an area wage index developed from Core Based Statistical Areas (CBSAs).

There is a Medicare training add-on payment that is computed by using the national average hourly wage for nurses from the Bureau of Labor Statistics. The payment accounts for nursing time for each training treatment that is furnished and is adjusted by the geographic area wage index. This amount is added to the ESRD PPS payment each time a training treatment is provided by the Medicare certified training ESRD facility. The ESRD PPS included consolidated billing requirements for defined ESRD-related Medicare Part B items and services. Certain renal dialysis laboratory services, limited drugs and biologicals, equipment, and supplies are subject to consolidated billing and are not separately payable when provided by non-ESRD facilities. ESRD facilities billing for any labs or drugs that meet the criteria will be considered part of the bundled PPS payment unless billed with the modifier AY.

[23] Centers for Medicare and Medicaid Services, *"ESRD PPS Consolidated Billing,"* (January 2020). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html

Under the ESRD PPS, payment is made on a per treatment basis. The ESRD PPS base rate is the per treatment unit of payment that applies to both adult and pediatric patients. ESRD facilities furnishing dialysis treatments in either a dialysis facility or in a patient's home are paid for up to three treatments per week unless there is medical justification for more than three weekly treatments. Therefore, ESRD facilities furnishing dialysis "in-facility" or in a patient's home are paid for a maximum of 13 treatments during a 30-day month and 14 treatments during a 31-day month unless there is medical justification for additional treatments.[24]

The finalized ESRD PPS base rate for CY 2018 was $232.37 and increased to $235.27 for CY 2019. The CY 2020 amount of $239.33 reflects a productivity-adjusted market basket increase of one-point seven percent (1.7%) and wage index budget-neutrality adjustment factor of just over one percent (1.000244%).[25]

Federally Qualified Health Centers

On October 1, 2014, FQHCs began transitioning from a cost-based per-visit payment to a prospective payment system (PPS) in which the Medicare payment is made based on a predetermined, fixed amount.[26] Under the FQHC PPS system, these facilities will be paid the lesser of their actual charges or the PPS rate for all FQHC services provided to a beneficiary on the same day as a medically-necessary, face-to-face FQHC visit.[27]

As referenced in section 1834(o)(1)(A) of the Social Security Act, "*the FQHC PPS base rate is adjusted for each FQHC by the FQHC geographic adjustment factor (GAF), based on the geographic practice cost indices (GPCIs) used to adjust payment under the Physician Fee Schedule (PFS). The FQHC GAF is adapted from the work and practice expense GPCIs and are updated when the work and practice expense GPCIs are updated for the PFS*."[30] The payment rate is increased each year by either an FQHC-specific index or the Medicare Economic Index (MEI) if an FQHC index is not available.[28,29,30]

In the CY 2018 Physician Fee Schedule (PFS) Final Rule, CMS finalized a proposal to update the FQHC PPS base payment rate using a 2013-based FQHC market basket. The final FQHC

[24] Centers for Medicare and Medicaid Services, "*End-Stage Renal Disease Prospective Payment System (PPS) Overview*,"(December 2020). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html
[25] Centers for Medicare and Medicaid, "*Changes and Updates to the ESRD PPS for CY 2020*," (October 2019). Available online: https://www.cms.gov/newsroom/fact-sheets/cy2020-end-stage-renal-diseasedurable-medical-equipment-final-rule-cms-1713-f
[26] Centers for Medicare and Medicaid Services, "*FQHC PPS*," (November 2019). Available online: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Index.html
[27] Centers for Medicare & Medicaid Services, *"Change Request 9348 - Update to the Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) – Recurring File Updates,"* (October 2015). Available online : https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3369CP.pdf
[28] Centers for Medicare and Medicaid Services, *Medicare Benefit Policy Manual Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services*," (December 2018) Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
[29] Centers for Medicare & Medicaid Services, *"Update to the Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) – Recurring File Updates,"* (October 2015). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9348.pdf

market basket for CY 2018 is one-point nine percent (1.9%), which is based on historical data through second quarter 2017. From January 1, 2018, through December 31, 2018, the FQHC PPS base payment rate is $166.60, representing a one-point nine percent (1.9%) payment increase above the 2016 base payment rate of $163.49.[31] The final FQHC market basket for CY 2019 is one-point nine percent (1.9%) which is based on historical data through second quarter 2018, making the CY 2019 PPS base payment rate $169.77. From January 1, 2020, through December 31, 2020, the FQHC PPS base payment rate is $173.50, representing a two-point two percent (2.2%) payment increase above the 2019 base payment.

Home Health

Medicare pays home health agencies (HHAs) through a prospective payment system that adjusts payment for the health condition and care needs of the beneficiary using a case-mix adjustment. The payment is also adjusted for geographic differences in local wages. The home health PPS provides payments for each 60-day episode of care. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin, with no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. There is also a special outlier provision to ensure appropriate payment for those beneficiaries that have the most expensive care needs.[32]

Section 3131(a) of the *Affordable Care Act* mandated that the Secretary of Health and Human Services (HHS) must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under section 1895(b)(3)(A)(i)(III) of the Act. This adjustment is to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, section 3131(a) of the *Affordable Care Act* mandates that this rebasing must be phased-in over a 4-year period in equal increments, not to exceed three-point five percent (3.5%) of the amount (or amounts), as of the date of enactment, applicable under section 1895(b)(3)(A)(i)(III) of the Act and be fully implemented by CY 2016.

Section 421(a) of the MMA, as amended by section 210 of the MACRA (Pub. L. 114–10), provides an increase of three percent (3%) of the payment amount otherwise made under section 1895 of the Act for home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010 and before January 1, 2018. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Act applicable to home health services

[31] Centers for Medicare & Medicaid Services, *"Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2020 - Recurring File Update,"* (January 2020). Available online : https://www.cms.gov/files/document/mm11500.pdf

[32] Centers for Medicare and Medicaid Services, "*Home Health PPS*," (October 2019) Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html

furnished during a period to offset the increase in payments resulting in the application of this section of the statute.[33]

Section 1895(b)(3)(B) of the Act requires that the standard prospective payment amounts for CY 2018 be increased by a factor equal to the applicable home health market basket update for those HHAs that submit quality data as required by the Secretary. This market basket increase is based on HIS Global Insight Inc.'s (IGI) third quarter 2017 forecast with historical data through the second quarter of 2017.[34]

Final Medicare home health rules for CY 2016 finalized reductions to the national standardized 60-day episode payment rate in CY 2016, CY 2017, and CY 2018 by point ninety-seven percent (0.97%) each year to account for estimated case-mix growth not related to increases in patient acuity between CY 2012 and CY 2014.[35]

Section 411(c) of the MACRA amended section 1895(b)(3)(B) of the Act, required the market basket percentage increase be one percent (1%) for CY 2018 home health payments. HHAs that do not report the required quality data will receive a two percent (2%) reduction to the home health market basket update.[36]

To determine the CY 2017 national, standardized 60-day episode payment rate, CMS started with the previous year's episode rate and applied a wage index budget neutrality factor of 1.0004, a case-mix weight budget neutrality factor of 1.0160 and a nominal case-mix growth adjustment of point ninety-nine percent (0.99%). CMS then applied a $80.95 rebasing adjustment, which was three-point five percent (3.5%) of the CY 2010 national, standardized 60-day episode payment rate of $2,312.94, to the national, standardized 60-day episode rate. The CY 2017 national standardized 60-day episode payment rate was $2,989.97.

The national standardized 60-day episode payment amount was $3,039.64 in CY 2018, and $3,154.27 in CY 2019. For CY 2020 the national standardized 60-day episode payment amount was $3,220.79.[37]

For episodes with four or fewer visits, Medicare pays national per-visit rates based on the type of practitioner providing the services. An episode consisting of four or fewer visits within a 60-day period receives what is referred to as a low-utilization payment adjustment (LUPA). Medicare also adjusts the national standardized 60-day episode payment rate for certain intervening events that are subject to a partial episode payment adjustment (PEP adjustment).

[33] Centers for Medicare and Medicaid Services, "*CMS Manual System Pub 100-04 Medicare Claims Processing*, *Transmittal 3624,"* (October 2016). Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3624CP.pdf
[34] Centers for Medicare and Medicaid Services, "*Federal Register, Vol. 82, No, 214,"* (November 2017). Available online: https://www.govinfo.gov/content/pkg/FR-2017-11-07/pdf/2017-23935.pdf
[35] Ibid.
[36] Ibid.
[37] Centers for Medicare and Medicaid Services, "*Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020*," (January 2020). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11536.pdf

For certain cases that exceed a specific cost threshold, an outlier adjustment may also be available.[38]

Hospice

CMS pays hospice agencies a daily rate for every patient-enrolled day, regardless of services provided each day, including, as of January 1, 2019, physician assistant (PA) services.[39] Note that if a PA is employed by the hospice, the hospice can bill Part A for physician services, though, if the PA is not employed by the hospice, the PA can bill Part B for physician services. Additionally, hospice care is available for two 90-day periods, and an unlimited number of 60-day periods. Payment is based on the beneficiary's needed level of care and is adjusted to account for differences in wages across markets. There are two hospice benefit caps:

- *Cap on number of inpatient days* — The number of inpatient days is limited to no more than twenty percent (20%) of total patient care days.
- *Aggregate payment cap* — Hospice agencies may not receive a payment that is greater than the hospice aggregate cap, which is based on the number of Medicare patients electing the hospice benefit within the cap period.

Beginning January 1, 2016 payments for Hospice routine home care (RHC) will be made at two different rates depending on the length of hospice service. A higher payment rate will be made for the first 60 days of hospice care with a reduced payment rate for days 61 and over. Additionally, starting January 1, 2016 a service intensity add-on (SIA) payment will be added to the per diem RHC payment for services furnished during the last seven days of a patient's life if the following criteria are met:

- Day is for RHC level of care
- Day occurs during the last seven days of a patient's life, and the patient is discharged or expired
- Direct patient care is provided by a registered nurse or social worker on that day during the7-day period for a minimum of 15 minutes and up to 4 hours total per day.

CMS updates rates annually to account for differences in wage rates among markets. Base rates are updated annually based on the hospital market basket update. For fiscal year (FY) 2013 through 2019, the Social Security Act requires a reduction of the hospital market basket using a productivity adjustment. For FYs 2013 through 2019, the market basket update under the Hospice Payment System were reduced by point three percent (0.3%); however, this reduction was subject to suspension for FYs 2014 through FY 2019 under conditions set out under Section 1814(i)(1)(C)(v) of the Social Security Act.

[38] Ibid.
[39] Centers for Medicare and Medicaid Services, "*Hospice Payment System: Payment System Series,"* (January 2019). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/hospice_pay_sys_fs.pdf

Section 411(d) of the MACRA amended section 1814(i)(1)(C) of the Act, states that for hospice payments for FY 2018, the market basket percentage increase is required to be one percent (1%). Therefore, the hospice payment update percentage for FY 2018 is one percent (1%) for hospices that submit the required quality data and negative one percent (1%) for hospice that do not submit the required quality data. The hospice cap amount for the cap year ending September 30, 2018, was $28,689.04 for hospices that submit quality data.[40] The hospice payment update percentage for FY 2019 was one point eight percent (1.8%) and the cap amount was $29,205.44.[41] For FY 2020, the hospice payment update percentage was two-point six percent (2.6%) and the cap amount $29,964.78.[42]

Inpatient Hospital

The CMS Acute Care Hospital Inpatient Prospective Payment System (IPPS) is the Medicare PPS used for acute care hospital inpatient stays. Under the IPPS, each case is categorized into a diagnosis related group (DRG) with a payment weight assigned to it based on the average resources used to treat patients in that particular DRG. Annually, Medicare publishes a final rule with revisions to the IPPS for the upcoming fiscal year which goes into effect on October 1 each year.[43]

Medicare Severity Diagnosis Related Groups (MS-DRG) Prospective Payment System

MS-DRGs are payment groups designed for the Medicare population. An example of this is maternity care: while Medicare covers almost no newborn deliveries, Medicaid covers 43% of newborn deliveries nationally.[44] MS-DRGs groups patients who have similar clinical diagnoses and similar procedures accrued during the inpatient hospital stay, which includes the patient's principal diagnosis and up to 24 secondary diagnoses. The PPS payment starts with a standard base payment (average cost per discharge) for operating and capital services. CMS adjusts the labor and non-labor components of the base rate, as appropriate, by a wage factor, a cost of living factor and for geographic differences in operating and capital costs. CMS then multiplies the adjusted base payment by the MS-DRG relative weight, which represents the average resources required to care for cases in that particular MS-DRG, relative to the average

[40] Centers for Medicare and Medicaid Services, "*Federal Register Vol. 82 No. 149,"* (August 2017). Available online: https://www.govinfo.gov/content/pkg/FR-2017-08-04/pdf/2017-16294.pdf

[41] Centers for Medicare and Medicaid Services, "*Federal Register Vol. 83 No. 151,"* (August 2018). Available online: https://www.govinfo.gov/content/pkg/FR-2018-08-06/pdf/2018-16539.pdf

[42] Centers for Medicare and Medicaid Services, "*Fiscal Year 2020 Hospice Payment Rate Update Final Rule*," (July 2019). Available online: https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2020-hospice-payment-rate-update-final-rule

[43] Centers for Medicare and Medicaid Services, "*Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Prospective Payment System (CMS-1715-F)," (August 2019). Available online:* https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2020-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0

[44] MACPAC Fact Sheet: Medicaid's Role in Financing Maternity Care, (January 2020). Available online: https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf

resources used to treat cases in all MS-DRGs. Cases that are extraordinarily costly receive additional outlier payments.[45]

The operating and capital components of the rate are each updated by different inflation factors by CMS. Congress sets the operating component update by considering the hospital market basket index projected increase and the update to the capital component using its analyses of inpatient hospital Medicare capital margins, among other factors. *Section 3401 of the Affordable Care Act* required that the IPPS operating market basket update be adjusted annually by changes in economy-wide productivity (effective FY 2012). The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period).[46] The net impact of this adjustment is to reduce payment. Appendix E of this report describes market baskets and other inflation indices.

Hospital Value-Based Purchasing

Established by the ACA, the Hospital Value-Based Purchasing (VBP) Program is a CMS initiative that provides adjustments to all acute IPPS hospitals' base operating DRG payments based on specific quality measures. The VBP Program rewards hospitals with incentive payments for the quality of care they provide to people with Medicare. Under the VBP program, CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2018. For FY 2018 and subsequent years, the law requires that the applicable percent reduction, the portion of Medicare payments available to fund the program's value-based incentive payments, remain at two percent (2%).[47] These reductions are used to fund value-based incentive payments for hospitals that meet or exceed performance standards on included program measures.

Medicare Quality Initiative

Hospitals must participate in the Medicare Quality Initiative to receive the full hospital market basket update percentage for the operating portion of the inpatient rate. CMS launched this initiative in FY 2013 with the goal of improving the quality of hospital care through collection and public dissemination of standardized hospital quality data.[48] With this initiative, value-based incentive payments are made to acute care hospitals based on either how well that hospital performs on certain quality measures compared to other hospitals or how much that hospital's

[45] Centers for Medicare and Medicaid Services, *"Acute Care Inpatient Prospective Payment System Payment System Fact Sheet Series"* (February 2019). Available online: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctsht.pdf
[46] Centers for Medicare and Medicaid Services, "*Actual Regulation Market Basket Updates*." Available online: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html
[47] Centers for Medicare and Medicaid Services, "*Hospital Quality Initiative,"* (April 2013). Available online: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/index.html
[48] Centers for Medicare and Medicaid Services, "*Hospital Quality Initiative,"* (April 2013). Available online: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/index.html

performance improves on certain quality measures during a baseline period. Beginning in FY 2015, CMS will reduce the annual payment rate update by one-quarter for those hospitals not submitting quality of care data.[49,50]

Hospitals Paid Outside Of the MS-DRG Prospective Payment System

Medicare's system excludes certain hospital types from the PPS and reimburses these based on reasonable costs subject to a hospital-specific annual limit or a separate PPS. For example:

- Medicare reimburses critical access hospitals one hundred one percent (101%) of reasonable costs.
- Medicare-Acquired Condition Reduction Program reimburses inpatient rehabilitation facilities, services furnished in psychiatric hospitals and psychiatric units of acute care hospitals and long-term care hospitals using unique prospective payment systems.

Hospital-Acquired Conditions

Section 3008 of the ACA establishes a program for IPPS hospitals to improve patient safety by imposing financial penalties on hospitals that perform poorly with regard to certain Hospital Acquired Conditions (HACs). The program, which began in FY 2015, reviews conditions that a patient did not have when they were admitted to the hospital but developed during the hospital stay. If a hospital ranks in the worst-performing twenty-five percent (25%) of all applicable hospitals, relative to the national average of HAC rate, a one-percent payment reductions is applied after all other IPPS per discharge payments are applied.[51]

Hospital Readmissions

Section 3025 of the ACA established the Hospital Readmissions Reduction Program which reduces IPPS payments to hospitals for excessive hospital readmissions. The HRRP program began in FY 2013 and was amended in FY 2019 by the 21st Century Cures Act, stipulating that hospitals must be compared to peers with a similar proportion of dually eligible patients. CMS calculates payment reductions during a rolling three-year performance period. Payment reductions are capped at three percent (3%) and are applied to Medicare fee-for-service base operating DRG payments during the fiscal year.[52]

Medicare Disproportionate Share Hospital Payments

[49] Centers for Medicare and Medicaid Services, Government Publishing Office, *"Federal Register Vol. 76 No. 88,"* (May 2011). Available online: https://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[50] Centers for Medicare and Medicaid Services, *"Hospital Inpatient Quality Reporting Program,"* (September 2017). Available online: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html
[51] Hospital-Acquired Condition Reduction Program (July 2019). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program
[52] Hospital Readmissions Reduction Program (August 2020). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program

The DSH payment is calculated as a percentage add-on to the basic DRG payment. The amount of DSH payment a hospital receives is determined by each hospital's DSH Patient Percent, or the sum of the percentage of Medicare inpatient days for patients eligible for both Medicare Part A and Supplemental Security Income, and the percentage of total inpatient days for patient eligible for Medicaid but not Medicare Part A[53,54] There are ten different formulae, depending primarily on urban or rural location and hospital size.

A hospital must have a minimum DSH percentage, which differs across hospital groups, to qualify for DSH payments. Urban hospitals with more than 100 beds have a lower threshold than hospitals in rural areas with less than 100 beds.

There are two methods for large hospitals in urban areas. The primary method is for a hospital to qualify based on a statutory formula that results in the DSH patient percentage addressed earlier. Under the primary method to qualify for DSH adjustments, the first computation includes the number of hospital patient days used by patients who, for those days, were entitled to both Medicare Part A and SSI (excluding State supplementation). This number is divided by the number of patient days used by patients under Medicare Part A for that same period.

The alternate special exception method is for large urban hospitals that can demonstrate that more than thirty percent (30%) of their total net inpatient care revenues come from State and local governments for indigent care (other than Medicare or Medicaid). The alternative computation includes hospital patient days used by patients who, for those days, were eligible for medical assistance under a state plan approved under title XIX (Medicaid), but who were not entitled to Medicare Part A. This number is divided by the total number of hospital patient days for that same period.[55]

Effective April 25, 2015 CMS published CMS Ruling "CMS-1498-R2" ("the amended Ruling"), which amended CMS Ruling 1498-R. Specifically, the amended Ruling revises the requirement that all cost reports covered under the original ruling have the Medicare-SSI component of the DSH payment adjustment calculated based on total days. Under the amended Ruling, providers will have the option, for cost reporting periods involving patient discharges prior to October 1, 2004, to have their Medicare-SSI fraction calculated based on either total days or covered days. For cost reporting periods that involve patient discharges occurring after October 1, 2004 (i.e., Federal fiscal year 2005 forward), the Medicare-SSI component of the DSH payment adjustment will be based on total patient days.[56]

Medicare Bundled Payments

[53] Disproportionate Share Hospital (September 2020). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInPatientPPS/dsh
[54] DSH Patient Percent = (Medicare SSI Days / Total Medicare Days) + (Medicaid, Non-Medicare Days / Total Patient Days)
[55] Centers for Medicare and Medicaid Services, "*Disproportionate Share Hospital,"* (November 2019). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Disproportionate_Share_Hospital.pdf
[56] Centers for Medicare and Medicaid Services, *"Disproportionate Share Hospital (DSH),"* (September 2020). Available online: https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/dsh.html

In a separate but related effort to the ACA provision on bundled payments, HHS announced in August 2011, the Bundled Payments for Care Improvement (BPCI) initiative through the Center for Medicare and Medicaid Innovation (CMMI).[57] The initiative consists of four models of care which link payments for multiple services beneficiaries receive during an episode of care:

- *Model 1 - Retrospective Acute Care Hospital Stay Only* includes only inpatient hospitalization services for all MS-DRGs. Medicare will pay participants traditional fee-for-service payment rates, less a negotiated discount. In return, participants may enter into gain-sharing arrangements with physicians. Model 1 concluded on December 31, 2016.[58]

- *Model 2 - Retrospective Acute Care Hospital Stay Plus Post-Acute Care* includes the inpatient hospitalization, physician, and post-discharge services. In this BPCI model, Medicare will continue to make fee-for-service payments to participants for Model 2 episodes of care while reconciling the total cost of care for the episode against a bundled payment amount target price set by CMS. A payment or recoupment is later made by Medicare based on the aggregate performance compared to the target price. The episode will end either 30, 60, or 90 days after hospital discharge. Participants can select up to 48 different clinical condition episodes. Medicare will pay participants their "expected" Medicare payments, less a negotiated discount. Starting July 1, 2015 every participating hospital had to transition at least one clinical episode to phase two in order to remain in the BPCI. The transition of all clinical episodes for all participants into phase two was complete on September 30, 2015 at which point phase one of BPCI ended.[59]

- *Model 3 - Retrospective Post-Acute Care Only* includes only post-discharge services which must begin within 30 days of discharge from the inpatient stay and will end either a minimum of 30, 60, or 90 days after the initiation of the episode. Participants can select up to 48 different clinical condition episodes. Payments will be made using the same method as in Model 2.[60]

- *Model 4 - Acute Care Hospital Stay Only* includes the inpatient hospitalization, physician, and related readmission services for 30 days after hospital discharge. Payments for all services provided during a patient's 30-day episode of care are included in a single bundled payment. Participants can select up to 48 different

[57] Center for Medicare and Medicaid Innovation, "*Bundled Payments for Care Improvement Initiative Frequently Asked Questions,"* (June 2012). Available online: http://innovation.cms.gov/Files/x/Bundled-Payments-FAQ.pdf
[58] Centers for Medicare and Medicaid Services, "*BPCI Model 1: Retrospective Acute Care Hospital Stay Only*". Available online: https://innovation.cms.gov/initiatives/BPCI-Model-1/index.html. Retrieved on: 12/15/2020
[59] Centers for Medicare and Medicaid Services, "*BPCI Model 2: Retrospective Acute & Post-Acute Care Episode*". Available online: https://innovation.cms.gov/initiatives/BPCI-Model-2/index.html. Retrieved on: 12/15/2020
[60] Centers for Medicare and Medicaid Services, "*BPCI Model 3: Retrospective Post-Acute Care Only*". Available online: https://innovation.cms.gov/initiatives/BPCI-Model-3/index.html. Retrieved on: 12/15/2020

clinical condition episodes with Medicare paying participants a prospectively determined amount.[61, 62]

The BPCI initiative was extended until September 30, 2018 for all BPCI Model 2, 3, and 4 Awardees that choose to sign an amendment extending their period of performance for all clinical episodes for up to two years.[63] In 2018 CMMI launched the BCPI Advanced Model. This model extends the goals of the other BCPI initiatives and supports providers investing in practice innovation and care redesign. The BCPI Advanced model enrolled its first cohort in October 2018 and the model performance period will run through December 31, 2023.[64]

Intermediate Care Facility

Medicaid coverage of Intermediate Care Facilities for individuals with intellectual disabilities (ICF-ID) services is available only in a residential facility licensed and certified by the state survey agency as an ICF-ID.[65]

Outpatient Hospital

Outpatient Prospective Payment System (OPPS) is the Medicare PPS used for hospital-based outpatient services and procedures. Under the OPPS, payment is predicated on the assignment of ambulatory payment classifications (APCs). Quarterly, Medicare publishes revisions to the OPPS with significant changes made annually for the upcoming fiscal year which goes into effect on January 1.

The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established relative weight for the service's clinical APC by a conversion factor to arrive at a national unadjusted payment rate for the APC. The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services in that APC. The conversion factor translates the relative weights into dollar payment amounts.

To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate, which is sixty percent (60%) of the geographic adjustment, is further adjusted by the hospital wage index for the area in which the hospital being paid is located.[66]

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[61] Centers for Medicare and Medicaid Services, "*Bundled Payments for Care Improvement (BPCI) Initiative: General Information*," (November 2019). Available online: http://innovation.cms.gov/initiatives/bundled-payments/index.html
[62] Centers for Medicare and Medicaid Services, "*BPCI Model 4: Prospective Acute Care Hospital Stay Only*". Available online: https://innovation.cms.gov/initiatives/BPCI-Model-4/index.html. Retrieved on: 12/15/2020
[63] Centers for Medicare and Medicaid Services, "*Bundled Payments for Care Improvement (BPCI) Initiative: General Information*," (April 2018). Available online: http://innovation.cms.gov/initiatives/bundled-payments/index.html
[64] Centers for Medicare and Medicaid Services, "BCPI Advanced". Available online: https://innovation.cms.gov/innovation-models/bpci-advanced
[65] Intermediate Care Facilities for Individuals with Intellectual Disability. Available online: https://www.medicaid.gov/medicaid/ltss/institutional/icfid/index.html
[66] Centers for Medicare and Medicaid Services, "*Hospital Outpatient Prospective Payment System: Payment System Fact Sheet Series*," (March 2020) Available online: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf

The remaining forty percent (40%) is not adjusted. Hospitals may also receive the following payments in addition to standard OPPS payments:

- Pass-through payments for specific drugs, biologicals and devices used in the delivery of services that meet the criteria for pass-through status (these items are generally too new to be well represented in data used to set payment rates).
- Outlier payments for individual services that cost hospitals much more than the payment rates for the services' APC groups. Community Mental Health Centers (CMHCs) have a separate outlier threshold from hospitals. Beginning January 1, 2017, outlier payments for each CMHC is capped at eight percent (8%) of the CMHC's total per diem payments.
- Transitional outpatient payments for cancer hospitals and children's hospitals.
- A rural adjustment (currently an increased payment of seven-point one percent (7.1%)) for most services furnished by Sole Community Hospitals (SCHs), which includes Essential Access Community Hospitals located in rural areas (effective January 1, 2006).

Laboratory

Historically, and through CY 2017, Medicare paid for outpatient clinical laboratory services based on a fee schedule. Payment was based on either the lesser of the amount billed by the laboratory, the local rate for a geographic area or a national limit. Each year rates were updated for inflation based on changes to the CPI. Beginning January 2018, The *Protecting Access to Medicare Act of 2014* (PAMA) revised the payment and coverage methodologies for clinical laboratory tests paid under the Clinical Laboratory Fee Schedule (CLFS). Applicable laboratories are required to report private payer payment rates and corresponding volumes of tests. The statutorily required collection of private payer rates for laboratory tests from applicable laboratories is the basis for the revised payment rates for most laboratory tests on the CLFS.[67] For the first six years (CY 2018 to CY 2023) of the revised payment rates, the statute also includes a phase-in approach for payment reductions. For the first three years (CY 2018 to CY 2020) revised payment reductions for most CLFS tests cannot exceed 10 percent (10%) per year. For the next three years (CY 2021 to CY 2023) the revised payment reductions for most CLFS test cannot exceed 15 percent (15%) per year.[68]

In addition, critical access hospitals are paid for outpatient laboratory tests on a reasonable cost basis, instead of by the fee schedule.

[67] Centers for Medicare and Medicaid Services. Available online: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-17.html?DLPage=1&DLEntries=10&DLFilter=Lab&DLSort=0&DLSortDir=descending

[68] Centers for Medicare and Medicaid Services, "*Clinical Laboratory Fee Schedule*," (February 2020). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Clinical-Laboratory-Fee-Schedule-Fact-Sheet-ICN006818.pdf

Nursing Facilities

Medicare's coverage of nursing facility services is based on the Skilled Nursing Facility Prospective Payment System (SNF PPS) and is limited to skilled nursing (nursing or rehabilitation) care. Medicare Part A covers up to 100 days of "skilled nursing" care per spell of illness at a Skilled Nursing facility (SNF). However, the conditions for obtaining Medicare coverage of a nursing home stay are quite stringent: the Medicare beneficiary must enter the nursing home no more than 30 days after a hospital stay that itself lasted for at least 3 days (not counting the day of discharge); the care provided in the nursing home must be for the same condition that caused the hospitalization (or a condition medically related to it); and the patient must receive a "skilled" level of care in the nursing facility that cannot be provided at home or on an outpatient basis. In order to be considered "skilled," nursing care must be ordered by a physician and delivered by, or under the supervision of, a professional such as a physical therapist, registered nurse, or licensed practical nurse. In addition, such care must be delivered daily. Based on 2019 NHEA data, Medicare provided about twenty-two percent (22%) of total payments to nursing facilities nationally.[69]

When the nursing facility determines that a patient is no longer receiving a skilled level of care, the Medicare coverage ends. In addition, beginning on day 21 through 100 of the nursing home stay, there is a copayment equal to one-eighth of the initial hospital deductible. This copayment will be paid by Medicaid for individuals who are eligible for both Medicare and Medicaid. Medicaid will also pay for days of care exceeding the Medicare limit.

Skilled nursing care can be provided by hospital-based or freestanding units. Certain Medicare-certified hospitals may also provide skilled nursing services in "swing beds" – the hospital beds used to provide acute care services.

Medicare pays SNFs a per diem rate under the SNF PPS. The prospective per diem rates are expected to cover all operating and capital costs that efficient facilities would be expected to incur in furnishing most SNF services, with certain high-cost, low-probability ancillary costs paid separately. CMS adjusts the per diem rates to reflect geographic differences in wage rates and patient case-mix, as defined by a case-mix adjusted patient classification system of Resource Utilization Groups (RUGs). CMS updates Medicare SNF PPS rates annually based on inflation according to the SNF Market Basket Index and to reflect changes in local wage rates, using the latest hospital wage index.[70] CMS also pays hospitals that provide long-term care services using a PPS. The ACA reduced the market basket update for skilled nursing facilities, beginning in 2012. The health reform law also further reduces payment by applying a multifactor

[69] Centers for Medicare and Medicaid Services, "*National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2019."* Available online: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

[70] Centers for Medicare and Medicaid Services, "*Skilled Nursing Facility Prospective Payment System: Payment System Series,"* (February 2020*).* Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/snfprospaymtfctsht.pdf

productivity adjustment to the market basket index for skilled nursing facilities, beginning in FY 2012.[71]

Figure B.2: SNF PPS Rate Factors[72]

Skilled Nursing Facility PPS	FY 18	FY 19	FY 20
Market Basket Update	2.6	2.8	2.8
Productivity Adjustment	0.6	0.8	0.4
Market Basket Update less Productivity Adjustment	2.0	2.0	2.4

Programs of All-inclusive Care for the Elderly (PACE)

PACE is a fully integrated Medicare program and Medicaid state plan option that provides community-based care and services to people aged 55 or older who meet a state's nursing home level of care criteria. CMS makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicare participant in the payment area. Prospective payments are made up of the pre-ACA county rate, unadjusted for Indirect Medical Education (IME), and multiplied by the sum of the individual risk score and the organization frailty score.[73]

Physician and Other Practitioners

Medicare reimburses physicians, independent radiologists, physical and occupational therapists, clinical social workers, optometrists, and nurse practitioners according to the Medicare Physician Fee Schedule (PFS), which is based on the Resource-Based Relative Value Scale (RBRVS) that was implemented in 1989. The RBRVS is based on the estimated cost of three components:

- Relative Value Units (RVU), which include:
  - A Work RVU, which reflects the relative level of time and intensity associated with furnishing a service.

[71] Most Medicare providers, other than physicians, receive annual market basket payment updates based on growth in the costs of goods and services or on the Consumer Price Index (CPI). Unlike physicians, these updates have historically not been subject to an annual adjustment to reflect increased productivity. ACA addressed this by providing annual productivity adjustments for each market basket or CPI update for various provider categories, including Nursing Facility.
[72] Centers for Medicare and Medicaid Services, *"Market Basket Data".* Available online: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html
[73] Centers for Medicare and Medicaid Services, *"Programs of All-Inclusive Care to the Elderly (PACE): Chapter 13 – Payments to PACE Organizations".* Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pace111c13.pdf

  - A Practice Expense (PE) RVU, which reflects the cost of maintaining a practice, such as renting office space, buying supplies and equipment, and staff costs.
  - Professional Liability Insurance (PLI) RVU, which reflects the cost of insurance.

- Conversion Factor (CF) — To determine a payment rate for a particular service, the three RVUs listed above are multiplied by a dollar conversion factor.
- Geographic Practice Cost Indices (GPCI) — GPCIs are adjustments made to the 3 RVUs to account for geographic variations in the costs of practicing medicine in different areas within the country.

CMS updates the conversion factor annually based on the MEI, updates the RVUs periodically and updates the geographic practice indices every 3 years. For FY 2019, there was a minimum GPCI of one.[74] For 2020, the minimum GPCI was one through December 18, 2020 as required by Section 1101 of the Further Continuing Appropriations Act of 2021 and Other Extensions Act, December 11, 2020.[75]

Medicare reimburses anesthesiologists at the lower of the actual charge for a service or the anesthesia fee schedule amount. Medicare calculates the anesthesia fee schedule amount using an anesthesia-specific conversion factor (adjusted for regional differences) and "base" and "time" units (15-minute increments). The relative complexity of an anesthesia service is measured by base units.[76] These base units are added to the time units and multiplied by the conversion factor to produce the fee schedule amount.

The ACA mandated that, by 2015, CMS begin applying a Value Modifier under the Medicare PFS through new requirements of the Physician Quality Reporting System (PQRS). The Value Modifier is an adjustment made on a per claim basis to Medicare payments for items and services under the Medicare PFS. The program rewards quality performance and lower costs but penalizes group practices who do not report data on quality measures for covered professional services. In 2017, payment adjustments apply to physician solo practitioners and physicians in groups of 2 or more EPs based on their performance in 2015. In 2018, in addition to physicians, payment adjustments will also apply to physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who are solo practitioners or in groups of 2 or more EPs based on their performance in 2016.[77,78] Calendar Year 2018 was

[74] American Academy of Pediatrics, "*2019 RBRVS".* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched
[75] Centers for Medicare and Medicaid Services, "CY 2020 PFS Final Rule GPCI Public Use Files with Work Floor (Updated 12/15/2020)," (November 2019). Retrieved December 18, 2020. Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F
[76] CMS generally determines its base units using those formulated by the American Society of Anesthesiologists in its 1988 *Relative Value Guide*.
[77] Centers for Medicare and Medicaid Services, "*The Value Modifier (VM) Program".* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram
[78] Centers for Medicare and Medicaid Services, "*CMS 2016 Physician Quality Reporting System (PQRS)*

the final payment adjustment period for the Value Modifier. The Value Modifier was replaced with the Quality Payment Program (QPP), which has two program tracks: the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models (APMs). The first performance period began on January 1, 2017.[79, 80, 81]

As a result of the COVID-19 public health emergency, CMS automatically enrolled most providers in the MIPS program's extreme and uncontrollable circumstances policy. Providers that either did not submit 2019 MIPS data or only submitted data for one performance category by April 30, 2020 automatically received neutral payment adjustments. Providers that submitted data for two or three performance categories were still eligible for positive or negative adjustments. For performance year 2020, providers must apply for reweighting of one or more performance categories due to the public health emergency.[82]

Prescription Drugs

Prescription drugs covered under Medicare Part B are reimbursed using the average sale price (ASP) methodology. In some cases, payment may be made through a competitive acquisition program. Beginning January 1, 2005, the payment limit for Medicare Part B drugs and biologicals that are not paid on a cost or perspective payment basis equals one hundred six percent (106%) of the ASP.[83] ASPs are updated quarterly to reflect new average sales prices provided by prescription drug manufactures. If the ASP exceeds the market price or average manufacturer price by a specified percentage, CMS updates the payment amount.

Effective January 1, 2006, Medicare Part D, a voluntary prescription drug benefit, went into effect. Outpatient prescription drugs covered under Part D are not subject to Medicare payment rules. Prices are determined through negotiations between prescription drug plans or Medicare Advantage prescription drug plans and drug manufacturers; the U.S. Secretary of Health and Human services is statutorily prohibited from intervening in Part D drug price negotiations. States may opt to use Medicaid funds to cover prescription drugs that Medicare does not cover,

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Payment Adjustment Toolkit," (November 2015). Available online: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PA_Toolkit.PDF

[79] Centers for Medicare and Medicaid Services, *"Transitioning from the Physician Quality Reporting System (PQRS) to the Merit-based Incentive Payment System (MIPS)*," (March 2018). Available online: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/TransitionResources_Landscape.pdf

[80] The Value Modifier will be waived for groups and solo practitioners, as identified by their Tax Identification Number (TIN) billed Medicare PFS items and services under the TIN during the Value Modifier period participated in one of the following models: Pioneer Accountable Care Organization (ACO) Model, Comprehensive Primary Care Initiative, Next Generation ACO Model, Oncology Care Model, and the Comprehensive ESRD Care Initiative.

[81] Centers for Medicare and Medicare Services, "*Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program, 42 CFR Parts 405, 410, 414, 424, and 425,"* (November 2017). Available online: https://www.federalregister.gov/documents/2017/11/15/2017-23953/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

[82] Centers for Medicare and Medicaid Services: Quality Payment Program, "COVID-19 Response," (December 2020). Available online: https://qpp.cms.gov/about/covid19?py=2019

[83] Centers for Medicare and Medicaid Services, "*Average Sales Price (ASP) Payment Methodology - Medicare Claims Processing Manual Chapter 17 - Drugs and Biologicals," (*June 2016). Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf

however states may not use Medicaid funds to supplement Medicare Part D reimbursement for drugs.[84]

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) directs CMS to update the statutory parameters for the defined standard Part D drug benefit each year. These parameters include the standard deductible, initial coverage limit, and catastrophic coverage threshold, and minimum copayments for costs above the annual out-of-pocket threshold. In addition, CMS is statutorily required to update the parameters for the low-income subsidy benefit and the cost threshold and cost limit for qualified retiree prescription drug plans eligible for the Retiree Drug Subsidy.[85,86]

Public Health, Federal

Public Health, Federal services are provided to the American Indian and Alaskan Native population by Tribal Contract Health Centers and Indian Health Centers. The Tribal Contract Health Centers are outpatient health care programs and facilities owned or operated by the Tribes or Tribal organizations. Indian Health Centers are FQHCs designated to provide comprehensive primary care and related services to the American Indian and Alaskan Native population.[87]

The Tribal Contract Health Centers are outpatient health care programs and facilities owned or operated by the Tribes or Tribal organizations. The *Medicare Prescription Drug, Improvement, and Modernization Act* of 2003, entitled *Limitation on Charges for Services Furnished by Medicare Inpatient Hospitals to Individuals Eligible for Care Purchased by Indian Health Programs*, entitles Indian Health Programs to pay "Medicare-like" rates to Medicare-Participating hospitals for patients receiving hospital services outside of the Indian Health Service (IHS). The IHS total payments to providers for these services cannot exceed the Medicare-like rate that is set forth in, *Limitation on Charges for Services Furnished by Medicare-Participating Hospitals to Indians*.[88]

Please see the section Federally Qualified Health Centers in Appendix B for more information on reimbursement for Indian Health Center services.

[84] Centers of Medicare and Medicaid Services, "*Calendar Year (CY) 2016 Jan - Sep Phased- down State Contribution Final Per-Capita Rates*," (October 2015). Available online: http://www.ffis.org/sites/default/files/public/cmcs_dsg_smd_-_cy2016q123.pdf
[85] Centers for Medicare and Medicaid Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter," (February 2015). Available online: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2016.pdf
[86] The Retiree Drug Subsidy is a program designed by CMS to encourage employers to continue to provide high quality employer sponsored drug coverage to retired employees who are Medicare eligible.
[87] Health Resources and Services Administration, "*Tribal and Urban Indian Health Centers,"* (May 2018). Available online: https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/tribal-urban-indian/index.html
[88] Centers of Medicare and Medicaid Services, "Indian Health Services Programs," (August 2012). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0734.pdf

Psychiatric Residential Treatment Facilities

Medicare does not cover services of psychiatric residential treatment facilities (PRTFs).

Rural Health Clinics

Medicare pays for Rural Health Clinics (RHCs) using an all-inclusive rate (AIR) per visit except for pneumococcal and influenza vaccines and their administration, which are paid at one hundred percent (100%) of reasonable cost, and psychiatric and psychological services, which are subject to the outpatient Mental Health fee schedule. While Medicare has transitioned FQHCs to a PPS, it is not doing so for RHCs. Payment is based on an all-inclusive payment methodology but is subject to a maximum payment per visit and annual reconciliation.

As stated in Chapter 13 of the Medicare Benefit Policy Manual "*Medicare pays eighty percent (80%) of the RHC AIR, subject to a payment limit, for medically necessary medical, and qualified preventive, face-to-face (one-on-one) visits with a RHC practitioner for RHC services*." The rate is subject to a payment limit, except for RHCs that have been exempted from the payment limit as described in regulations at 42 CFR 413.65. As also described in Chapter 13 of the Medicare Benefit Policy Manual "*an interim rate for newly certified RHCs is established based on the RHC's anticipated average cost for direct and supporting services*." The normal process for calculating AIR for an RHC involves dividing the total allowable costs for the RHC by the total number of visits for all patients, with productivity, payment, and other factors also used in the calculation.[89] In the calculation of AIR for a RHC, allowable costs should be reasonable and may include the following: practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services. All services related to a RHC professional service are included in the per-visit payment and are not billed separately from the visit.[90]

The RHC upper payment limit per visit for CY 2018 is $83.45 per visit, and one-point four percent (1.4%) increase over CY 2017.[91] The RHC upper payment limit per visit for CY 2019 is $84.70 per visit, and one-point five percent (1.5%) increase over CY 2018.[92,93] For CY 2020, the

[89] Centers for Medicare and Medicaid Services, *"Medicare Benefit Policy Manual, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services,"* Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
[90] Ibid.
[91] Centers for Medicare and Medicaid Services, *"Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2018"* (November 2017). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10333.pdf
[92] Centers for Medicare and Medicaid Services, *"Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2019"* (October 2018). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10989.pdf
[93] Calculated by multiplying the Calendar Year 2018 rate by the Medicare Economic Index and reflects a 1.5 percent increase.

upper payment per visit is $86.31, representing a one-point nine percent (1.9%) increase from 2019.[94,95]

Vision

Medicare Part B covers vision services related to eye diseases and other covered services. To qualify as a covered item, a vision related service should: be covered in a defined benefit category; be reasonable and necessary for the diagnosis or treatment of an illness, injury, or improvement of function and not be excluded as a non-covered service. These services are reimbursed through the Medicare Physician fee schedule.[96] Beneficiaries may also receive extra vision benefits, including routine eye exams, if they are enrolled in Medicare Part C (Medicare Advantage) and pay an extra premium.[97]

Waiver Services

Generally speaking, Medicare does not cover most of the services covered by Wyoming Medicaid's waiver programs:

- Community Choices Waiver
- Children's Mental Health (CMH) Waiver
- Comprehensive and Supports Waiver[98]
- Pregnant by Choice Waiver

[94] Centers for Medicare and Medicaid Services, *"Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2020"* (October 2019). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11498.pdf

[95] Calculated by multiplying the Calendar Year 2019 rate by the Medicare Economic Index and reflects a 1.9 percent increase.

[96] The Physician and Other Practitioner Section of this report provides more information on the Medicare Physician Fee Schedule.

[97] Centers for Medicare and Medicaid Services, *"Medicare Vision Services,"* (April 2018) Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/VisionServices_FactSheet_ICN907165.pdf

[98] In SFY 2018, the Wyoming Department of Health Behavioral Health Division performed a rate study to update and consolidate three waivers (Acquired Brain Injury Waiver, Comprehensive Waiver, and Supports Waiver) into the Comprehensive and Supports Waiver.