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 fee-for-service 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

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

Ambulance

Ambulance services include both emergency and nonemergency transport from the point of patient pick-up to an appropriate medical facility. Medicare fee for-service (FFS) program spending for ambulance services in 2019 (not including cost sharing paid by beneficiaries) was $4.5 billion, or about 1 percent of total Medicare FFS spending, and approximately 11 percent of all Medicare FFS beneficiaries used ambulance services.[1]

Medicare uses a prospective fee schedule methodology to pay for ambulance services. The fee schedule payment for these services includes a base rate payment and a separate payment for mileage to the nearest appropriate facility. [2] The payment covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with the transport. Therefore, the single payment is inclusive of items and services such as oxygen, drugs, extra attendants, and EKG testing when such services are medically necessary. 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.[3] In addition, under the prospective fee schedule, Medicare pays for each "loaded mile."[4] 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. Centers for Medicare & Medicaid Services (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) for recent years is shown below:

- CY 2018 1.1%
- CY 2019 2.3%
- CY 2020 0.9%
- CY 2021 0.2%[5]

[1] MedPAC, "*Ambulance Services Payment System*," (November 2021). Available online: https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_ambulance_final_sec.pdf
[2] Centers for Medicare and Medicare Services, "*Ambulance Fee Schedule Public Use Files*," (March 2022). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf
[3] MedPAC, "*Ambulance Services Payment System*," (November 2021)., Available online: https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_ambulance_final_sec.pdf
[4] A loaded mile is a mile during which a Medicare beneficiary is transported in an ambulance.
[5] Centers for Medicare and Medicaid Services, "*Medicare Claims Processing Manual – Chapter 15,"* (2021). Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf

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
- *T*he *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).*

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%).[6]

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.[7]

Two additional rural add-on payments exist. The rural short-mileage ground ambulance add-on payment policy increases the standard mileage rate by fifty percent (50%) for the first 17 miles of a ground transport if the pick-up ZIP code is rural. The rural air transport add-on payment policy reimburses providers and suppliers fifty percent (50%) more than the urban air ambulance base payment and the mileage rate if the point-of-pickup ZIP code is rural.[8]

CMS has developed a survey tool, commonly referred to as the Medicare Ground Ambulance Data Collection Instrument, which will be used to measure the adequacy of payments for ground ambulance services and measure geographic variations in the cost of furnishing such services. The survey tool is web based and ambulance providers will begin entering data into the tool in

[6] 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
[7] Ibid.
[8] MedPAC, "*Ambulance Services Payment System*," (November 2021). Available online: https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_ambulance_final_sec.pdf

calendar year 2022. The survey will collect detailed information on ground ambulance provider and supplier characteristics including service areas, service volume, costs, and revenue through a data collection instrument.[9] This survey of costs and revenues was planned to begin in calendar year 2020, and was postponed because of the COVID-19 Public Health Emergency (PHE).

Impact of the COVID-19 Public Health Emergency

To help combat the COVID-19 PHE, 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 now covers transport to COVID-19 testing facilities, alternative hospital sites, urgent care facilities, and physician offices in addition to other newly permitted locations. Medicare is also paying for treatment in place without a transport if a community-wide emergency medical service protocol precludes transport of a patient due to the COVID-19 PHE (e.g., if ambulances have been instructed not to transport patients to hospitals if they have virtually no chance of survival).[10] In addition, CMS is modifying the data collection period and data reporting period, as defined at 42 CFR §414.626(a), for ground ambulance organizations that were selected by CMS to collect data beginning between January 1, 2020, and December 31, 2020 (Year 1) and for ground ambulance organizations that were selected to collect data beginning between January 1, 2021 and December 31, 2021 (Year 2). Under this modification, these ground ambulance organizations can select a new data collection period that begins between January 1, 2022, and December 31, 2022; collect the necessary data during their selected data collection period; and submit the data during the data-reporting period that corresponds to their selected data collection period.[11]

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."[12] 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.

[9] Centers for Medicare and Medicaid Services, "*Federal Register Vol. 86 No. 221,"* (November 2021) Available online: https://www.federalregister.gov/documents/2021/11/19/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part
[10] MedPAC, "*Ambulance Services Payment System*," (November 2021)., Available online: https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_ambulance_final_sec.pdf
[11] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[12] 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/

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.[13] In its annual updates to the ASC payment system, CMS sets relative payment weights equal to OPPS relative payment weights for the same services and then scales the ASC weights to maintain budget neutrality.[14]

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 multifactor productivity (MFP) adjustment from the Consumer Price Index for all urban consumers (CPI-U) in order to get the MFP-adjusted CPI-I update factor.[15] 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.[16] 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. For CY 2021, CMS increased the ASC rates by two-point four percent (2.4%) based on the basket increase of two-point four percent (2.4%) minus a zero percent (0.0%) MFP adjustment.[17]

ASCs 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. In addition, CMS has alternate payment methods for office-based procedures, device-intensive procedures, covered ancillary radiology services, and drugs and biologicals. [18]

Impact of the COVID-19 Public Health Emergency

During the PHE, an ASC may furnish inpatient services under arrangement for a hospital, or become provider-based to a hospital, or choose to enroll as a hospital themselves. ASCs that enroll as a hospital will be paid as a hospital under the appropriate part of Medicare depending on whether the patient is admitted (i.e., inpatient vs. outpatient) and will be subject to all Medicare payment policies and limitations to the extent not waived. Instead of ASC Prospective Payment System (PPS) rates, an ASC that is enrolling as a hospital during the PHE is paid

[13] 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

[14] 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

[15] 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

[16] 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

[17] Centers for Medicare and Medicaid Services, "*Federal Register Vol. 85 No. 249,"* (December 2020). Available online: https://www.govinfo.gov/content/pkg/FR-2020-12-29/pdf/2020-26819.pdf

[18] Centers for Medicare and Medicaid Services. "*Medicare Payment Systems*," (October 2021). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Ambulatory

under the outpatient prospective payment system (OPPS) for outpatient claims and the inpatient prospective payment system (IPPS) payment system for inpatient claims.[19]

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, and 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 paid at approximately sixteen percent (16%) of the amount a physician is paid under the Medicare physician fee schedule.[20,21]

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 that provides the service.[22,23,24] 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.[25]

Hospital inpatient behavioral health services provided at specialty inpatient psychiatric hospitals and Medicare-certified Distinct Part (DP) psychiatric units in acute care hospitals and Medicare-certified DP psychiatric units in Critical Access Hospitals (CAHs) are paid through the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). The IPF PPS pays via per diem rate which is calculated as a per diem base rate adjusted for facility and patient characteristics. Additional payments are made for electroconvulsive therapy (ECT) treatments and IPF-eligible "outlier cases" (cases with extraordinarily high costs). The per diem, ECT and outlier payments cover facility costs. Covered services provided by physicians, physician

[19] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

[20] Please see the Physician and Other Practitioner section for more information on the Medicare Physician Fee Schedule.

[21] 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

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

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

[24] 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

[25] 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). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F

assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, qualified psychologist services, or certified registered nurse anesthetists are paid separately using the Medicare Physician Fee Schedule.[26]

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.[27] 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 pays 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.

There are unique scenarios in which dental services are covered by Medicare. These include the extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and an oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery or performed in an RHC/FQHC prior to a heart valve replacement.[28]

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.[29] Medicare used to have a national Competitive Bidding Program (CBP) for various DMEPOS services, but all contracts expired on December 31, 2018.[30] As of January 1, 2019, there was a

[26] Centers for Medicare and Medicaid Services. "*Medicare Payment Systems*," (October 2021). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Ambulatory
[27] Centers for Medicare and Medicaid Services, "*Medicare Dental Coverage,*" (March 2014). Available online: http://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html
[28] Ibid.
[29] 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
[30] 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

temporary gap in this program until December 31, 2020.[31] Medicare renewed the competitive bidding program for a small select set of product categories effective January 1, 2021 through December 31, 2023.

DMEPOS Fee Schedule

Medicare limits payments for DMEPOS 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.[32] CMS releases new payment amounts semi-annually 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.[33] 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.[34] For calendar year 2021, a point-two percent (0.2%) update factor has been applied to the DMEPOS fee schedule, which is based on a point-six percent (0.6%) increase in the CPI-U reduced by a point-four percent (0.4%) increase in the MFP. The point-two percent fee schedule update factor does not apply to product categories included in the Round 2021 Competitive Bidding Program.[35]

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

[31] 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
[32] Centers for Medicare and Medicaid Services, "*Durable Medical Equipment, Prosthetics/Orthotics & Supplies Fee Schedule*,". Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html?redirect=/dmeposfeesched/
[33] 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
[34] 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
[35] CMS Medicare Learning Network, "*CY 2021 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule*,". (December 2020), Available online: https://www.cms.gov/files/document/mm12063.pdf

payment amounts, to 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, which lasts from January 1, 2019 until December 31, 2020, 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.

Competitive Bidding Program Round 2021

Medicare renewed the competitive bidding program for a small select set of product categories effective January 1, 2021 through December 31, 2023. This two-year span, referred to as "Round 2021," sets single payment amounts (SPAs) for the Off-The-Shelf (OTS) back brace and OTS knee brace product categories. The product categories are defined by a specific set of Healthcare Common Procedure Coding System (HCPCS) codes. The SPAs replace the standard DMEPOS fee schedule amounts in 127 competitive bidding areas.[36]

Non-Competitive Bidding Areas (Non-CBAs)

Since 2016, CMS has been paying different fee schedule amounts based on information from competitive bidding program for certain DME and enteral nutrients, supplies, and equipment furnished in non-CBAs, depending on where the item or service is furnished: 1) rural areas and non-contiguous areas, or 2) non-rural areas within the contiguous U.S. The fee schedule amounts for non-rural contiguous non-CBAs are adjusted based on one hundred percent (100%) of the average payment amounts under the CBP while the fee schedule amounts for rural and non-contiguous non-CBAs are adjusted based on a blend of fifty percent (50%) of the adjusted fee schedule amounts (adjusted based on information from the CBP) and fifty percent (50%) of the higher historic, unadjusted fee schedule amounts.[37]

Impact of the COVID-19 Public Health Emergency

Medicare was in the process of reducing DMEPOS fee schedule rates based on historical rates obtained through the CBP when the COVID-19 PHE began. During the PHE, Medicare is putting these rate reductions on hold and leaving the rates at or above values that existed when the PHE began.[38] Specifically, in accordance with section 3712(b) of the Coronavirus Aid,

[36] Centers for Medicare and Medicaid Services, "*DMEPOS Competitive Bidding - Home*," (December 2021). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid
[37] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[38] CMS Medicare Learning Network, "*CY 2021 Update for Durable Medical Equipment, Prosthetics,*

Relief, and Economic Security Act (CARES Act), fee schedule amounts for DME items and services furnished non-rural and contiguous non-CBAs are adjusted based on a blend of seventy-five percent (75%) of the adjusted fee schedule amounts and twenty-five percent (25%) of the higher historic, unadjusted fee schedule amounts from March 6, 2020 through the duration of the PHE period. Section 3712(a) continues the 50/50 blend in rural and non-contiguous non-CBAs.[39]

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), which includes a 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) whether the services are delivered in an ESRD facility or in a beneficiary's home. Consolidated billing requirements confer the ESRD facility the payment responsibility for all 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.[40]

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).

Orthotics and Supplies (DMEPOS) Fee Schedule,". (December 2020), Available online: https://www.cms.gov/files/document/mm12063.pdf

[39] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

[40] 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

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 the payment 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 includes 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.

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.[41]

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%).[42] In CY 2021, the ESRD PPS base rate is $253.13. This amount reflects the application of the wage index budget-neutrality adjustment factor of point ninety-nine percent (.999485), the addition to the base rate of $9.93 to include calcimimetics, and a productivity-adjusted market basket increase as required by section 1881(b)(14)(F)(i)(I) of the Act (1.6 percent), equaling $253.13 (($239.33 × .999485) + $9.93) × 1.016 = $253.13).[43]

In CY 2020, Medicare finalized a new add-on payment, which provides new incentives to encourage the provision of dialysis in the home and encourage kidney transplants for ESRD beneficiaries. The add-on payment is called the "transitional add-on payment adjustment for new and innovative equipment and supplies (TPNIES)." In CY 2021, Medicare finalized changes to the eligibility criteria and determination process for the TPNIES to include new and innovative capital-related assets that are home dialysis machines. For each new product, CMS evaluates the application to determine whether the home dialysis machine represents an advance that

[41] 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

[42] 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

[43] Centers for Medicare and Medicaid Services, "*Federal Register Vol. 85 No. 217,"* (November 2020) Available online: https://www.govinfo.gov/content/pkg/FR-2020-11-09/pdf/2020-24485.pdf

substantially improves, relative to renal dialysis services previously available, the diagnosis or treatment of Medicare beneficiaries.[44]

Impact of the COVID-19 Public Health Emergency

As a result of the COVID-19 PHE, some ESRD facilities are experiencing higher than normal volume. To compensate, Medicare is holding harmless ESRD facilities that would otherwise qualify for the Low Volume Payment Adjustment (LVPA) but for a temporary increase in dialysis treatments furnished in 2020. For purposes of determining LVPA eligibility for payment years 2021, 2022, and 2023, Medicare will only consider total dialysis treatments furnished for any 6 months of a facility's cost-reporting period ending in 2020; ESRD facilities select those 6 months (consecutive or nonconsecutive) during which treatments will be counted for purposes of the LVPA determination.[45]

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 national rate which is adjusted based on the location of where the services are furnished.[46] Under the FQHC PPS system, these facilities are paid the lesser of their actual charges or the PPS rate for all FQHC services provided to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary.[47]

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*."[48] 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.[49,50,51]

The FQHC PPS rate for a covered visit is calculated as follows:

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[44] Ibid.
[45] Ibid.
[46] 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
[47] 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
[48] 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
[49] 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
[50] 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

Base payment rate x FQHC GAF = PPS rate

The rate is increased by 34.16 percent when a patient is new to the FQHC, or an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) is furnished. In this case, the FQHC PPS rate is calculated as follows:

Base payment rate x FQHC GAF x 1.3416 = PPS rate

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 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.[52] 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.

For CY 2021, the FQHC PPS base payment rate was determined using a 2017 base year for the FQHC market basket. The 2017-based FQHC market basket update for CY 2021 is two-point four percent (2.4%). The multifactor productivity adjustment for CY 2021 is point seven percent (0.7%). The final CY 2021 FQHC payment update is one-point seven percent (1.7%). The resulting FQHC PPS base payment rate effective from January 1, 2021, through December 31, 2021, is $176.45.[53]

In the 2019 Physician Fee Schedule (PFS) Final Rule, CMS finalized a policy that, effective January 1, 2019, FQHCs can receive payment for virtual communication services when at least 5 minutes of communication technology-based or remote evaluation services are furnished by a FQHC practitioner to a patient who has had a FQHC billable visit within the previous year, and both of the following requirements are met:

- The medical discussion or remote evaluation is for a condition not related to a FQHC service provided within the previous 7 days, and
- The medical discussion or remote evaluation does not lead to a FQHC visit within the next 24 hours or at the soonest available appointment.

Virtual communication services are considered separate and distinct from telehealth services. Telehealth services are considered a substitute for an in-person visit, whereas virtual communication services are brief discussions with the FQHC practitioner to determine if a visit

[52] 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

[53] Centers for Medicare & Medicaid Services, *"Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021 Fact Sheet,"* (December 2020). Available online : https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1

is necessary. If the discussion between the FQHC practitioner and the Medicare beneficiary results in a billable visit, then the usual FQHC billing would occur, and the virtual communication service is not payable.[54] Virtual communication services are billed using HCPCS code G0071 and are paid at $13.69 in CY 2019, $24.76 in CY 2020, and $23.18 in CY 2021.

Impact of the COVID-19 Public Health Emergency

COVID-19 vaccines and their administration are paid the same way influenza and pneumococcal vaccines and their administration are paid in FQHCs. Influenza and pneumococcal vaccines and their administration are paid at one hundred percent (100%) of reasonable cost through the cost report. The beneficiary coinsurance and deductible are waived.[55] Specimen collection services, on the other hand, are included in the prospective payment system for FQHCs and are not paid separately, including a specimen collection for COVID-19 testing.[56]

During the COVID-19 PHE, coinsurance and deductible (if applicable) do not apply for certain evaluation and management services when they are related to COVID-19 testing, whether they are furnished in person or via telehealth.[57]

Section 3704 of the CARES Act authorizes FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. FQHCs with this capability can provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE. Distant site telehealth services can be furnished by any health care practitioner working for the FQHC within their scope of practice. Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS). Claims for G2025 are paid at the CY 2021 rate of $99.45. The CY 2022 rate is $97.24.[58]

Several codes on the Medicare telehealth list describe telephone (audio only) evaluation and management (E/M) services (CPT codes 99441-99443), and CMS has used waiver authority to allow some behavioral health and patient education services to be furnished using audio-only technology, as well. These services are included on the Medicare telehealth list which can be found at this website:

[54] Centers for Medicare & Medicaid Services, *"Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions,"* December 2018. Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf
[55] Centers for Medicare & Medicaid Services, *"Federally Qualified Health Centers (FQHC) Center,"* Available online: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center
[56] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[57] Ibid.
[58] Centers for Medicare & Medicaid Services, *"Federally Qualified Health Centers (FQHC) Center,"* Available online: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

Unless indicated otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between the patient and distant site physician or practitioner.[59]

During the COVID-19 PHE, payment for virtual communication services include digital assessment services. Digital assessment services are non-face-to-face, patient-initiated, digital communications using a secure online patient portal. The digital assessment codes that are billable during the COVID-19 PHE are CPT code 99421 (5-10 minutes over a 7-day period), CPT code 99422 (11-20 minutes over a 7-day period), and CPT code 99423 (21 minutes or more over a 7-day period).[60]

FQHCs can bill for visiting nursing services furnished by a registered nurse (RN) or licensed practical nurse (LPN) to homebound individuals under a written plan of treatment in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020 and for the duration of the COVID-19 PHE, the area included in the FQHC service area plan is determined to have a shortage of home health agencies, and no request for this determination is required. FQHCs must check the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.[61]

In general, the requirements for direct supervision have been modified for the duration of the COVID-19 PHE to include the use of a virtual supervisory presence through the use of interactive audio and video telecommunications technology.[62]

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 provided payments for each 60-day episode of care prior to CY 2020. Starting in CY 2020, the home health PPS provides payments for each 30-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

[59] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[60] Centers for Medicare & Medicaid Services*, "Federally Qualified Health Centers (FQHC) Center,"* Available online: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center
[61] Ibid.
[62] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

can receive. There is also a special outlier provision to ensure appropriate payment for those beneficiaries that have the most expensive care needs.[63]

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 furnished during a period to offset the increase in payments resulting in the application of this section of the statute.[64]

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.[65]

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.

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

[63] 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
[64] 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
[65] 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

is based on HIS Global Insight Inc.'s (IGI) third quarter 2017 forecast with historical data through the second quarter of 2017.[66]

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 receive a two percent (2%) reduction to the home health market basket update.[67]

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 period payment rate changed to 30 days and the national standardized 30-day episode payment amount was $1,864.03. For CY 2021, the 30-day episode payment amount for agencies that submit quality data is $1,901.12. In addition, a small rural add-on payment is applied in CY 2019 – 2022 depending on the category of rural area.[68]

For episodes beginning prior to January 1, 2020, Medicare pays episodes with four or fewer visits using 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). For certain cases that exceed a specific cost threshold, an outlier adjustment may also be available.[69]

Changes Effective January 1, 2020

The Bipartisan Budget Act of 2018 (BBA of 2018) included several requirements for home health payment reform, effective January 1, 2020. These requirements included the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of payment to a 30-day period payment rate. The statutorily required provisions in the BBA of 2018 resulted in the Patient-Driven Groupings Model, or PDGM. The PDGM removes the current payment incentive to overprovide therapy, and instead, is designed to focus more heavily on clinical characteristics and other patient information to better align Medicare payments with patients' care needs. The new, standardized 30-day period payment rate applies if a period of care meets a certain threshold of home health visits. This payment rate is adjusted for case-mix and geographic differences in wages. Also, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. 30-day periods of care that do not meet the visit threshold are paid via a Low Utilization Payment Adjustment (LUPA), which is a per-visit payment rate for the discipline providing care.[70] The

[66] Ibid.
[67] Ibid.
[68] Centers for Medicare and Medicaid Services, "*Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2021*," (November 2020). Available online: https://www.cms.gov/files/document/mm12017.pdf
[69] 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
[70] Centers for Medicare and Medicaid Services, "*Home Health PPS*," Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html

LUPA threshold varies for a 30-day period of care depending on the payment group to which it is assigned. For each payment group, the 10th percentile value of visits is used to create a payment group-specific LUPA threshold with a minimum threshold of at least 2 visits for each group.[71]

Case-Mix Adjustment

After a physician or allowed practitioner prescribes a home health plan of care, the HHA assesses the patient's condition and determines the skilled nursing care, therapy, medical social services, and home health aide service needs, at the beginning of the 60-day[72] certification period. The assessment must be done for each subsequent 60-day certification. A nurse or therapist from the HHA uses the Outcome and Assessment Information Set (OASIS) instrument to assess the patient's condition.

Certain OASIS items describing a patient's condition, and other information reported on Medicare claims are used to determine the case-mix adjustment to the national, standardized 30-day payment rate. 30-day periods are categorized into 432 case-mix groups for the purposes of adjusting payment under the PDGM. In particular, 30-day periods are placed into different subgroups for each of the following broad categories:

Information obtained from Medicare claims:

- *Admission Source* (two subgroups): Community or Institutional
- *Timing of the 30-day period* (two subgroups): Early or Late
- *Clinical Grouping* - Based on the reported principal diagnosis (twelve subgroups): Musculoskeletal Rehabilitation; Neuro/stroke Rehabilitation; Wounds; Medication Management, Teaching, and Assessment (MMTA) - Surgical Aftercare; MMTA - Cardiac and Circulatory; MMTA - Endocrine; MMTA - Gastrointestinal Tract and Genitourinary System; MMTA - Infectious Disease, Neoplasms, and Blood-forming Diseases; MMTA - Respiratory; MMTA- Other; Behavioral Health; or Complex Nursing Interventions
- *Comorbidity Adjustment* - Based on the reported secondary diagnoses (three subgroups): None, Low, or High

Information obtained from the OASIS assessment:

- *Functional Impairment Level* (three subgroups): Low, Medium, or High

In total, there are 2*2*12*3*3 = 432 possible case-mix adjusted payment groups.[73]

Outlier Payments

[71] Centers for Medicare and Medicaid Services, "*Medicare Benefit Policy Manual Chapter 7 - Home Health Services*," (May 2021) Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

[72] While the unit of payment for home health services is currently a 30-day period payment rate, there are no changes to timeframes for re-certifying eligibility and reviewing the home health plan of care, both of which occur every 60-days (or in the case of updates to the plan of care, more often as the patient's condition warrants).

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

Additional payments are made to the 30-day period case-mix adjusted payments for beneficiaries who incur unusually large costs. These outlier payments are made for periods of care where imputed cost exceeds a threshold amount for each case-mix group. The amount of the outlier payment is a proportion of the amount of imputed costs beyond the threshold. Outlier costs are imputed for each period of care by applying standard per-visit amounts to the number of visits by discipline (skilled nursing visits, or physical, speech-language pathology, occupational therapy, or home health aide services) reported on the claims. Total national outlier payments for home health services annually may be no more than two-point five percent (2.5%) of estimated total payments under home health PPS.[74]

Practitioners Authorized to Order Home Health Services

In March 2020, Section 3708(f) of the CARES Act amended the regulations to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) to certify and order home health services. This means that in addition to a physician, these "allowed practitioners" may certify, establish, and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare home health benefit.[75]

Impact of the COVID-19 Public Health Emergency

Section 3707 of the CARES Act encouraged use of telecommunications systems for home health services furnished during the COVID-19 PHE. In response, CMS amended § 409.43(a), allowing the use of telecommunications technology to be included as part of the home health plan of care, as long as the use of such technology does not substitute for an in-person visit ordered on the plan of care. HHAs may even perform Medicare-covered initial assessments and determine patients' homebound status remotely, by phone, or by record review. Utilization of telecommunications technology is also an option for the completion of the comprehensive assessment and the update of the comprehensive assessment. It would be up to the clinical judgment of the home health agency and patient's physician/practitioner as to whether such technology can meet the patient's need. The use of telecommunications technology in furnishing services under the home health benefit must be included on the plan of care and the plan of care must outline how such technology will assist in achieving the goals outlined on the plan of care.[76]

CMS is not enforcing the current national and local coverage determinations that otherwise restrict coverage of home-use of oxygen during the COVID-19 PHE. This change is intended to allow practitioners flexibility to treat their patients with home-use of oxygen during this emergency. This enforcement discretion only applies during the PHE for the COVID–19 pandemic.[77]

[74] Ibid.
[75] Ibid.
[76] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[77] Ibid.

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.[78] 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, CMS began making payments for Hospice routine home care at two different rates depending on the length of hospice service. A higher payment rate is paid 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 is added to the per diem routine home care payment for services furnished during the last seven days of a patient's life if the following criteria are met:

- Day is for routine home care 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 the 7-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 updates 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.

Section 411(d) of the MACRA amended section 1814(i)(1)(C) of the Act and 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

[78] 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

(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.[79] The hospice payment update percentage for FY 2019 was one-point eight percent (1.8%) and the cap amount was $29,205.44.[80] For FY 2020, the hospice payment update percentage was two-point six percent (2.6%) and the cap amount $29,964.78.[81] For 2021, the hospice payment update percentage was two-point four percent (2.4%) and the cap amount was $30,683.93.[82]

Impact of the COVID-19 Public Health Emergency

Hospices are able to furnish services using telecommunications technology during the PHE when a patient is receiving routine home care. This can include telephone calls (audio only or TTY), two-way audio-video telecommunications technology that allow for real-time interaction between the patient and clinician (e.g., FaceTime, Skype), and remote patient monitoring. It would be up to the clinical judgment of hospice as to whether such technology can meet the patient's/caregiver's/family's needs and the use of technology should be included on the plan of care for the patient and family.[83]

Hospital – Inpatient

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 hospital admission 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.[84]

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

MS-DRGs are payment groups and associated relative weights designed for the Medicare population. As a result, MS-DRG data is heavily influenced by health care provided to elderly

[79] 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
[80] 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
[81] 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
[82] Centers for Medicare and Medicaid Services, "*Fiscal Year 2021 Hospice Payment Rate Update Final Rule CMS-1733-F Fact Sheet*," (July 2020). Available online: https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2021-hospice-payment-rate-update-final-rule-cms-1733-f
[83] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[84] 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

beneficiaries. MS-DRGs group patients who have similar clinical diagnoses and similar procedures accrued during the inpatient hospital stay. These are identified through the patient's principal diagnosis and up to 24 secondary diagnoses along with up to 25 surgical procedure codes submitted on the inpatient claim. Each MS-DRG is assigned a relative weight which represents the average resources required to care for cases in that particular MS-DRG, relative to the average resources used to treat cases in all MS-DRGs.

The PPS payment starts with a standard base rate (average cost per discharge) for operating and capital services. CMS adjusts the labor component of the base rate by a wage factor applicable to the area where the hospital is located, and if the hospital is located in Alaska or Hawaii, the non-labor share is adjusted by a cost of living adjustment factor. DRG base payment is calculated as adjusted base rate multiplied by the MS-DRG relative weight.[85]

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 sets the capital component update 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).[86] The net impact of this adjustment is to reduce payment. Appendix E of this report describes market baskets and other inflation indices.

Additions to Medicare IPPS Base Payment

If the hospital treats a high-percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment. This add-on, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payment for hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculation.

Also, if the hospital is an approved teaching hospital it receives a percentage add-on payment for each case paid through IPPS. This add-on known as the indirect medical education (IME) adjustment, varies depending on the ratio of residents-to-beds under the IPPS for operating costs, and according to the ratio of residents-to-average daily census under the IPPS for capital costs.

[85] 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

[86] 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

Finally, for particular cases that are unusually costly, known as outlier cases, the IPPS payment is increased. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG base payment, plus any DSH or IME adjustments.[87]

Qualifying for Medicare Disproportionate Share Hospital Payments

Qualifying for DSH payments is based on the DSH Patient Percentage (DPP), 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 patients eligible for Medicaid but not Medicare Part A[88,89] 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 is a second method to qualify for DSH 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. 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.[90]

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.[91]

Medicare Disproportionate Share Hospital Payments

The DSH payment is calculated as a percentage add-on to the basic DRG payment.

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[87] Centers for Medicare & Medicaid Services, *“Acute Inpatient PPS,”* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS

[88] Centers for Medicare & Medicaid Services, *“Disproportionate Share Hospital,”* (September 2020). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInPatientPPS/dsh

[89] DSH Patient Percent = (Medicare SSI Days / Total Medicare Days) + (Medicaid, Non-Medicare Days / Total Patient Days)

[90] 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

[91] Centers for Medicare and Medicaid Services, *“Disproportionate Share Hospital (DSH),”* Available online: https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/dsh.html

Prior to FY 2014, the DSH payment percentage calculation was based on a set of ten formulas. Each formula utilized the DSH Patient Percentage. Which of the ten formulas applied to an individual hospital depended on hospital-specific information, including:

- Geographic designation (urban or rural)
- Number of beds
- Rural Referral Center Status

The resulting annual DSH payment percentage is referred to as the "the empirically justified amount."

Effective for discharges occurring on or after FY 2014, hospitals will receive twenty-five percent (25%) of the amount they previously would have received under the pre-2014 statutory formula for Medicare DSH – the empirically justified amount. The remainder, equal to seventy-five percent (75%) of what otherwise would have been paid as Medicare DSH, will become available for uncompensated care payments after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive an uncompensated care payment based on its share of uncompensated care relative to the amount of uncompensated care for all DSH hospitals expressed as a percentage. Prior to FY 2021, uncompensated care was measured as insured low-income days, that is, the sum of Medicaid days and Medicare SSI days. Starting with FY 2021, CMS calculated uncompensated care payments for eligible hospitals using audited Worksheet S-10 data from FY 2017 cost reports. However, for Indian Health Service (IHS) or Tribal Hospitals and Puerto Rico hospitals, CMS continued to use the older method, basing its calculation on low-income insured proxy days. For FY 2022 and subsequent FYs, except for IHS or Tribal hospitals and Puerto Rico hospitals, CMS will calculate each hospital's uncompensated care payments using the most recent available single year of audited Worksheet S-10 data.[92]

Each hospital's uncompensated care payment is the product of three factors. These three factors are:

- Seventy-five percent (75%) of the estimated DSH payments that would otherwise be made under the old DSH methodology (section (d)(5)(F) of the Social Security Act),
- 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured (minus point one (0.1) percentage points for FY 2014, and minus point two (0.2) percentage points for FY 2015 through FY 2017), and
- A hospital's amount of uncompensated care relative to the amount of uncompensated care for all DSH hospitals expressed as a percentage.[93]

Indirect Medical Education Payments

[92] Centers for Medicare & Medicaid Services, Medicare Learning Network, *"Medicare Disproportionate Share Hospital Fact Sheet,"* (March 2021). Available online: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/disproportionate_share_hospital.pdf

[93] Centers for Medicare & Medicaid Services, *"Acute Inpatient PPS – Disproportionate Share Hospital,"* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment for each Medicare discharge to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals. The additional payment is based on the IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as r, and a multiplier, which is represented as c, in the following equation: c x [(1 + r).405 - 1]. The multiplier c is set by Congress. Thus, the amount of IME payment that a hospital receives is dependent upon the number of residents the hospital trains and the current level of the IME multiplier.[94]

Direct Graduate Medical Education Payments

Medicare makes Direct Graduate Medical Education payments to hospitals for the costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act, as added by The Consolidated Omnibus Budget Reconciliation Act (COBRA), sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of beginning between October 1, 1983, through September 30, 1984). Medicare direct GME payments are calculated by multiplying the PRA times the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and non-hospital sites, when applicable), and the hospital's Medicare share of total inpatient days.[95]

DRG Outlier Payments

Section 1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers). The actual determination of whether a case qualifies for outlier payments considers both operating and capital costs and DRG payments. That is, the combined operating and capital costs of a case must exceed the fixed loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to eighty percent (80%) of the combined operating and capital costs in excess of the fixed-loss threshold (ninety percent (90%) for burn DRGs).[96]

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[94] Centers for Medicare & Medicaid Services, *"Acute Inpatient PPS – Direct Graduate Medical Education,"* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME

[95] Centers for Medicare & Medicaid Services, *"Acute Inpatient PPS – Indirect Medical Education,"* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME

[96] Centers for Medicare & Medicaid Services, *"Acute Inpatient PPS – Outlier Payments,"* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier

Hospitals Paid Outside of the MS-DRG Prospective Payment System

Medicare's system excludes certain hospital types from the IPPS and reimburses these based on reasonable costs subject to a hospital-specific annual limit or via a separate PPS. For example, critical access hospitals, specialty children's hospitals, and eleven (11) specific specialty cancer hospitals are paid outside of the IPPS. In addition, Medicare uses separate, unique prospective payment systems for inpatient rehabilitation facilities (IRF PPS), services furnished in psychiatric hospitals and psychiatric units of acute care hospitals (IPF PPS), and long-term care hospitals (LTCH PPS).

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.[97] 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 performance improves on certain quality measures during a baseline period. Beginning in FY 2015, CMS reduced the annual payment rate update by one-quarter for those hospitals not submitting quality of care data.[98,99] Specific quality incentive-based payment programs that have been implemented are described in the following sections.

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. 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%).[100] These reductions are used to fund value-based incentive payments for hospitals that meet or exceed performance standards on included program measures. The applicable quality categories and their weights for FY 2021 are shown below:

[97] 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
[98] 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
[99] 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
[100] Centers for Medicare and Medicaid Services, "*Hospital Value-Based Purchasing Program,"* (April 2013). Available online: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-

- Clinical Outcomes (25 percent)
- Person and Community Engagement (25 percent)
- Safety (25 percent)
- Efficiency and Cost Reduction (25 percent)

Hospital-Acquired Conditions Reduction Program

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's HAC rate ranks in the worst-performing twenty-five percent (25%) of all applicable hospitals, relative to the national average of HAC rate, a one percent (1%) payment reduction is applied after all other IPPS per discharge payments are applied.

CMS uses the Total HAC Score to determine the worst-performing quartile of all subsection (d) hospitals based on data for six quality measures:

- One claims-based composite measure of patient safety:
  - Patient Safety and Adverse Events Composite (CMS PSI 90)
- Five chart-abstracted measures of healthcare–associated infections (HAI), submitted to the Centers for Disease Control and Prevention's National Healthcare Safety Network:
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI) for abdominal hysterectomy and colon procedures
  - Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
  - Clostridium difficile Infection (CDI)

The HAC Reduction Program is a separate and distinct program from the Hospital-Acquired Conditions Present on Admission Indicator (HAC POA) provision established by the Deficit Reduction Act (DRA) of 2005.[101]

Hospital-Acquired Conditions (Present on Admission Indicator)

Section 5001(c) of Deficit Reductions Act required the Secretary to identify conditions that could reasonably have been prevented through the application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of those preventable conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present.[102]

Hospital Readmissions

[101] Centers for Medicare and Medicaid Services, "*Hospital-Acquired Condition Reduction Program*" Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program
[102] Centers for Medicare and Medicaid Services, "*Hospital-Acquired Condition Present on Admission Indicator*," Available online: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond

Section 3025 of the ACA established the Hospital Readmissions Reduction Program (HRRP) which reduces IPPS payments to hospitals for excessive hospital readmissions. The program is intended to encourage hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable 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.

CMS includes the following six condition or procedure-specific 30-day risk-standardized unplanned readmission measures in the program:

- Acute myocardial infarction (AMI)
- Chronic obstructive pulmonary disease (COPD)
- Heart failure (HF)
- Pneumonia
- Coronary artery bypass graft (CABG) surgery
- Elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA)[103]

Medicare Bundled Payments

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).[104] 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 paid 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.[105]

- *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.

[103] Centers for Medicare and Medicaid Services, "*Hospital Readmissions Reduction Program*," Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program
[104] 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
[105] 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.

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.[106]

- *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.[107]

- *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 clinical condition episodes with Medicare paying participants a prospectively determined amount.[108, 109]

The BPCI initiative was extended until September 30, 2018 for all BPCI Model 2, 3, and 4 Awardees that chose to sign an amendment extending their period of performance for all clinical episodes for up to two years.[110] In 2018 CMMI launched the BPCI Advanced Model continuing efforts to implement voluntary episode payment models. This model extends the goals of the other BPCI initiatives and supports providers investing in practice innovation and care redesign. The BPCI Advanced model enrolled its first cohort in October 2018 and the model performance period will run through December 31, 2023. The second cohort started on January 1, 2020. [111]

BPCI-Advanced is defined by following characteristics:

- Voluntary Model
- A single retrospective bundled payment and one risk track, with a 90-day Clinical Episode duration
- 8 Clinical Episode Service Lines Groups starting Model Year 4 (30 Inpatient, 3 Outpatient and 1 multi-setting Clinical Episode categories)
- Qualifies as an Advanced Alternative Payment Model (AAPM)

[106] 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.
[107] 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.
[108] 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
[109] 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.
[110] 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
[111] Centers for Medicare and Medicaid Services, "BPCI Advanced," Available online: https://innovation.cms.gov/innovation-models/bpci-advanced

- Payment is tied to performance on Quality Measures
- Preliminary Target Prices provided prior to each Model Year

The BPCI Advanced Model uses a retrospective bundled payment approach. Specifically, under BPCI Advanced, CMS may make payments to Model Participants or Model Participants may owe a payment to CMS after CMS reconciles all non-excluded Medicare FFS expenditures for a Clinical Episode against a Target Price for that Clinical Episode.[112]

Impact of the COVID-19 Public Health Emergency

Medicare will use the standard DRG payment calculation method for discharges of patients who have a COVID-19 diagnosis. In addition, there is no special DRG for COVID-19. However, Section 3710 of the CARES Act directs the Secretary to increase the IPPS weighting factor of the assigned diagnosis-related group (DRG) by 20 percent (20%) for an individual diagnosed with COVID-19 discharged during the COVID-19 PHE period. CMS will multiply the current MS-DRG relative weight for the discharge by a factor of 1.20 when calculating a hospital's operating IPPS payment.[113]

The DRG rate (and outlier payments as applicable) includes payment for when a patient needs to be isolated or quarantined in a private room as a result of COVID-19. In addition, Medicare payments for health care services include payment for the supplies necessary to appropriately provide the service, including any personal protective equipment and supplies appropriate for the patient's condition and treatment. There are no separate payments for personal protective equipment and supplies necessary to prevent the spread of COVID-19. Also, hospitals may not bill for and receive separate Medicare FFS payment for COVID-19 testing services on the day of inpatient admission, the day immediately preceding inpatient admission, and, for most hospitals, the two days prior to that. Critical Access Hospitals (CAHs) may bill and receive separate payment for COVID-19 testing services provided in the outpatient department prior to an inpatient admission because they are not subject to the IPPS payment window policy.[114]

Medicare will make a payment to the provider or supplier for the monoclonal antibody product to treat COVID-19 (when the product is not received by the provider for free) and make a separate payment for its administration (infusion). Medicare will not pay for the monoclonal antibody products to treat COVID-19 that health care providers receive for free, as will be the case upon the product's initial availability in response to the COVID-19 PHE. If health care providers begin to purchase these monoclonal antibody products in the future, CMS anticipates setting the Medicare payment rate for the product, which will be reasonable cost or 95% of the average wholesale price for many health care providers, consistent with usual vaccine payment methodologies.[115]

[112] Ibid.
[113] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[114] Ibid.
[115] Ibid.

During the COVID-19 PHE, CMS is allowing hospitals to provide inpatient and outpatient hospital services in temporary expansion sites, which may include ambulatory surgical centers (ASCs), repurposed gymnasiums, erected tents, or other sites, to help address the urgent need to expand their care capacity and to develop COVID-19 specific treatment sites. In addition, Medicare enrolled hospitals that assume the majority operations of a temporary expansion site – including gymnasiums, tents, convention centers, and others – that was built or retrofitted by a public entity can bill Medicare for covered inpatient and outpatient hospital services provided to Medicare beneficiaries at those temporary expansion sites.[116]

CMS, under the waiver authority provided in section 1135 of the Social Security Act (42 U.S.C. 1320b-5), is modifying the requirements at 42 CFR 482.23(c)(3) to allow a hospital to administer any COVID-19 vaccine, authorized under an FDA Emergency Use Authorization without an individual clinician order.[117]

CMS delayed the filing deadline of Fiscal Year End (FYE) 10/31/2019 and FYE 11/30/2019 cost reports until June 30, 2020. CMS also delayed the filing deadline of the FYE 12/31/2019 cost reports until August 31, 2020. For the FYE 01/31/2020 cost report, the extended due date is August 31, 2020. For the FYE 02/29/2020 cost report, the extended due date is September 30, 2020. For any cost reporting period not previously identified and ending on a date falling in the period of March 1, 2020 through December 31, 2020, providers are granted an additional 60 days from the initial due date to file their cost reports.[118]

In the March 31, 2020 COVID-19 IFC (85 FR 19230), CMS amended the regulation in 42 CFR 415.172 to state that for the duration of the PHE, the requirement for the presence of a teaching physician during the critical or key portion of a procedure can be met, at a minimum, through direct supervision by interactive telecommunications technology. In other words, the teaching physician must provide supervision either with physical presence or be present through interactive telecommunications technology during the critical key portion of the service.[119]

To hold teaching hospitals harmless from a reduction in IME payments caused by a temporary increase in the number of available hospital beds to accommodate an expected influx of COVID-19 patients, CMS announced that beds temporarily added during the PHE for COVID-19 will be excluded from the calculations to determine IME payment amounts in accordance with 42 CFR § 412.105(d)(1). Similarly, CMS is holding IPF and IRF teaching status adjustment payments harmless for the duration of the PHE. This means the teaching status adjustment amounts for the IRF and IPF hospitals and units of hospitals will be the same during the COVID-19 PHE as they were on the day before the PHE was declared, in order to hold their teaching status adjustment payments harmless during the pandemic. Also, CMS has changed the regulations so that a hospital that is paying a resident's salary and fringe benefits can claim that resident for IME and DGME purposes when the resident is working at home or in a patient's

[116] Ibid.
[117] Ibid.
[118] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[119] Ibid.

home and is performing duties within the scope of the approved residency program and is meeting appropriate physician supervision requirements. This allows residents to perform their duties in alternate locations, including their home or a patient's home, so long as it meets appropriate physician supervision requirements.[120]

Hospital – Outpatient

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 amount 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.[121] 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). Pass through payments are applied for a drug, biological or devices for at least 2 years but not more than 3 years.
- 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 are 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

[120] Ibid.
[121] 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

includes Essential Access Community Hospitals located in rural areas (effective January 1, 2006).

- Beginning CY 2020, for claims with APCs that require implantable devices and have significant device offsets (greater than 30%), Medicare applies a device offset cap based on the credit amount listed in the "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) value code.

Hospital Outpatient Services Paid Outside of the OPPS

Medicare pays some services separately, including but not limited to:

- Certain clinical diagnostic laboratory tests
- Blood and blood products
- Most clinic and ED visits
- Some drugs, biologicals, and radiopharmaceuticals
- Brachytherapy sources
- Therapy services
- Screening and diagnostic mammography
- Certain prosthetic devices and orthotic devices
- Certain durable medical equipment supplied by the hospital for the patient to take home
- Partial hospitalization
- Certain COVID-19 vaccine administration services

Many of the services carved out of the OPPS, such as outpatient therapy services and Screening and diagnostic mammography are paid via a fee schedule. Prescription drugs and biologicals costing less per day than a specific threshold get packaged in the OPPS. Those above the threshold are paid separately by the average hospital acquisition cost. The OPPS drug packaging threshold for CY 2021 is $130.[122] Partial hospitalization is paid on a per diem basis. The payment represents the expected daily cost of care in facilities, hospital outpatient departments, and CMHCs.

Hospitals Carved Out of the OPPS

The following hospitals are not reimbursed under the OPPS:

- Hospitals providing only inpatient Part B services
- Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) and Tribal hospitals, including IHS Tribal CAHs
- Hospitals located outside of the 50 States, the District of Columbia, and Puerto Rico (American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the Virgin Islands)
- Hospitals in Maryland and those paid under Maryland All-Payer Model

[122] Centers for Medicare and Medicaid Services, "*Federal Register Vol. 85 No. 249,"* (Dated December 29, 2020) Available online: https://www.govinfo.gov/content/pkg/FR-2020-12-29/pdf/2020-26819.pdf

Impact of the COVID-19 Public Health Emergency

Although Medicare usually doesn't allow payment for services that are paid for by a governmental entity, there is an exception for services furnished as a means of controlling infectious diseases (see 42 CFR 411.8(b)(4)). Hospitals may bill Medicare for resources (e.g., supplies and staffing assistance) to help with the COVID-19 emergency accepted from Federal, State, or local governments.[123]

Medicare will make a payment to the provider or supplier for the monoclonal antibody product to treat COVID-19 (when the product is not received by the provider for free) and make a separate payment for its administration (infusion). Medicare will not pay for the monoclonal antibody products to treat COVID-19 that health care providers receive for free, as will be the case upon the product's initial availability in response to the COVID-19 PHE. If health care providers begin to purchase these monoclonal antibody products, CMS anticipates setting the Medicare payment rate for the product, which will be reasonable cost or 95% of the average wholesale price for many health care providers, consistent with usual vaccine payment methodologies. [124]

In general, CMS has revised the definition of direct supervision to include, during the PHE, a virtual presence through the use of interactive telecommunications technology, for services paid under the Physician Fee Schedule as well as for hospital outpatient services. The revised definition of direct supervision also applies to pulmonary, cardiac, and intensive cardiac rehabilitation services during the PHE. Additionally, CMS changed the supervision requirements from direct supervision to general supervision, and to allow general supervision throughout hospital outpatient non-surgical extended duration therapeutic services.[125]

During the COVID-19 PHE, CMS is allowing hospitals to provide inpatient and outpatient hospital services in temporary expansion sites, which may include ambulatory surgical centers (ASCs), repurposed gymnasiums, erected tents, or other sites, to help address the urgent need to expand their care capacity and to develop COVID-19 specific treatment sites. In addition, Medicare enrolled hospitals that assume the majority operations of a temporary expansion site – including gymnasiums, tents, convention centers, and others – that was built or retrofitted by a public entity can bill Medicare for covered inpatient and outpatient hospital services provided to Medicare beneficiaries at those temporary expansion sites.[126]

In addition, flexibilities exist during the COVID-19 PHE to enable hospitals to furnish outpatient services in a patient's home and treat the patient's home as a provider-based outpatient department (PBD). Under the CMS IFC published in the Federal Register on May 8th, CMS is temporarily expanding the extraordinary circumstances relocation exception policy during the PHE to include both on-campus and excepted off-campus PBDs that relocate (or partially

[123] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[124] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[125] Ibid.
[126] Ibid.

relocate) to new off-campus locations, including to any temporary expansion locations (such as other sites or the patient's home, as applicable), due to the PHE. This policy applies to relocations occurring on or after March 1, 2020 (85 FR 27560) and will last until the end of the PHE. Further, CMS is streamlining the process for relocating PBDs to seek an exception and will allow PBDs to immediately begin furnishing and billing for services at the new location while the regional office is reviewing the exception request.[127]

A hospital with an on-campus provider-based department (PBD) that relocates off-campus (including to a home) for the PHE and applies for a Temporary Extraordinary Circumstances Relocation Request would bill for services provided by that department with the "PO" modifier, which indicates a service was provided at an excepted off-campus PBD. It would be paid the OPPS payment rate (including the reduced rate for visits at excepted off-campus departments). On the other hand, if an on-campus or excepted off-campus provider-based department relocates (including to a home) and does not seek a temporary extraordinary circumstances relocation request, the hospital should bill services with the "PN" modifier so that the services are paid the non-excepted Physician Fee Schedule-equivalent rate. Effective since 2018, the PFS Relativity Adjuster that applies to these services is 40 percent (40%) of the OPPS rate.[128]

Intermediate Care Facility

Medicaid coverage of Intermediate Care Facilities for individuals with intellectual disabilities (ICF-IID) services is available only in a residential facility licensed and certified by the state survey agency as an ICF/IID.[129] Medicare does not cover services provided in an ICF/IID.[130]

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

[127] Ibid.
[128] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[129] Centers for Medicare and Medicaid Services, "*Intermediate Care Facilities for Individuals with Intellectual Disability*," Available online: https://www.medicaid.gov/medicaid/ltss/institutional/icfid/index.html
[130] Connected Risk Solutions, "*What is an Intermediate Care Facility*," Available online: https://connectedrisksolutions.com/what-is-an-intermediate-care-facility/

payer rates for laboratory tests from applicable laboratories is the basis for the revised payment rates for most laboratory tests on the CLFS.[131] The first data collection period (the period where applicable information for an applicable laboratory is obtained from claims for which the laboratory received final payment during the period) was from January 1, 2019 through June 30, 2019. The next data reporting period of January 1, 2023 through March 31, 2023 will be based on the original data collection period of January 1, 2019 through June 30, 2019. Subsequent reporting periods will occur every three years (that is, 2026, 2029, etc.)[132]

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 tests cannot exceed 15 percent (15%) per year.[133] However, these reductions have been postponed slightly. No reduction will be applied for calendar years 2021 and 2022. And the current plan is to apply the 15 percent (15%) per year reduction in calendar years 2023, 2024, and 2025.[134]

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

Impact of the COVID-19 Public Health Emergency

CMS is changing the Medicare payment rules during the PHE for the COVID-19 pandemic to provide payment to independent laboratories for specimen collection from beneficiaries who are homebound or inpatients not in a hospital for COVID19 testing under certain circumstances.[135]

Each beneficiary may receive Medicare coverage for one COVID-19 and related test without the order of a physician or other health practitioner, but Medicare will require such an order to cover further COVID-19 and related tests. [136]

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

[131] 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
[132] Centers for Medicare and Medicaid Services, "*Clinical Laboratory Fee Schedule*," Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched
[133] Centers for Medicare and Medicaid Services, "*Clinical Laboratory Fee Schedule*," Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Clinical-Laboratory-Fee-Schedule-Fact-Sheet-ICN006818.pdf
[134] Centers for Medicare and Medicaid Services, "*Clinical Laboratory Fee Schedule*," Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched
[135] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[136] Ibid.

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.[137]

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 is paid by Medicaid for individuals who are eligible for both Medicare and Medicaid. Medicaid 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. 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.[138] 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 productivity adjustment to the market basket index for skilled nursing facilities, beginning in FY 2012.[139]

Prior to October 1, 2019, Medicare used the Resource Utilization Groups (RUGs) case-mix patient classification system for the purposes of case-mix adjusting per diem rates. Beginning October 1, 2019, CMS shifted to the Patient Driven Payment Model (PDPM) case-mix classification model for purposes of case-mix adjustment. CMS feels the PDPM improves

[137] 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

[138] 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

[139] 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.

payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided. Under PDPM case-mix measurement, each patient is classified into a group for each of the five case-mix adjusted components: Physical Therapy, Occupational Therapy, Speech Language Pathology, Nursing and Non-Therapy Ancillary. Patient overall case-mix is the sum of the patient's scores in each of these five components. In addition, PDPM includes a "Variable Per Diem (VPD) adjustment" that adjusts the per diem rate over the course of the stay.[140]

Figure B.2: SNF PPS Rate Factors[141]

Skilled Nursing Facility PPS	FY 18	FY 19	FY 20	FY 21
Market Basket Update	2.6	2.8	2.8	2.2
Productivity Adjustment	0.6	0.8	0.4	0.0
Market Basket Update less Productivity Adjustment	2.0	2.0	2.4	2.2

Impact of the COVID-19 Public Health Emergency

During the PHE, Medicare has waived the requirement for an inpatient hospital stay of at least 3 consecutive days before a stay in a skilled nursing facility will be covered. This waiver applies to all SNF-level beneficiaries under Medicare Part A, regardless of whether the care the beneficiary requires has a direct relationship to COVID-19.[142]

In addition, CMS is allowing therapy services to be furnished to a Part A SNF resident remotely during the COVID-19 PHE (consistent with state scope of practice laws), based on the clinical judgment of the therapist that the therapy being furnished is appropriate to be provided remotely and continues to meet the SNF level of care requirements.[143]

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

[140] Medicare Learning Network, *"SNF PPS: Patient Driven Payment Model Presentation,"* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/MLN_CalL_PDPM_Presentation_508.pdf
[141] 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
[142] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[143] Ibid.

Education (IME), and multiplied by the sum of the individual risk score and the organization frailty score.[144]

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.
  - 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.[145] 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.[146] The minimum GPCI is also one for CYs 2021, 2022 and 2023.[147]

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

[144] 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
[145] American Academy of Pediatrics, "*2019 RBRVS".* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched
[146] Centers for Medicare and Medicaid Services, "*CY 2020 PFS Final Rule GPCI Public Use Files with Work Floor (Updated 12/15/2020)*," (November 2019). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F
[147] Centers for Medicare and Medicaid Services, *"Physician Fee Schedule".* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched

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.[148] 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 eligible health care professionals (EPs) based on their performance in 2015. In 2018, in addition to physicians, payment adjustments 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.[149,150] Calendar Year 2018 was 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.[151, 152, 153]

Impact of the COVID-19 Public Health Emergency

As a result of the COVID-19 PHE, 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

[148] CMS generally determines its base units using those formulated by the American Society of Anesthesiologists in its 1988 *Relative Value Guide*.
[149] Centers for Medicare and Medicaid Services, "*The Value Modifier (VM) Program".* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram
[150] Centers for Medicare and Medicaid Services, "*CMS 2016 Physician Quality Reporting System (PQRS) Payment Adjustment Toolkit,"* (November 2015). Available online: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PA_Toolkit.PDF
[151] 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
[152] 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.
[153] 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

performance year 2020, providers must apply for reweighting of one or more performance categories due to the PHE.[154]

Physicians and other practitioners who are permitted to bill under Medicare can bill Medicare for covered professional services that are furnished to Medicare beneficiaries at temporary expansion sites, including gymnasiums, or other non-clinical locations. In addition, all health care practitioners who are authorized to bill Medicare for their professional services may also furnish and bill for telehealth services. This allows health care professionals who were not previously authorized under the statute to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.[155]

For purposes of the PHE for the COVID-19 pandemic, Medicare has added several codes that describe telephone-only services to the list of Medicare telehealth services. These include CPT codes 99441–99443, which describe audio-only evaluation and management (E/M) phone visits with practitioners who can independently bill for E/M services. While these codes are ordinarily limited to established patients, during the PHE, Medicare will make payment for them for both new and established patients. On an interim basis during the PHE for the COVID-19 pandemic, Medicare payment for CPT codes 99441-99443 for claims with dates of service on or after March 1 is increased to align with the payment rates for the level 2–4 established patient office/outpatient E/M services (CPT codes 99212-99214). In addition, while not currently on the Medicare telehealth services list, during the PHE for COVID-19, CMS pays CPT codes 98966–98968, which describe audio-only telephone assessment and management visits for practitioners who cannot independently bill for E/M phone visits, for example certain therapists, social workers, and clinical psychologists.[156]

In general, CMS has revised the definition of direct supervision to include, during the PHE, a virtual presence through the use of interactive telecommunications technology, for services paid under the Physician Fee Schedule as well as for hospital outpatient services. The revised definition of direct supervision also applies to pulmonary, cardiac, and intensive cardiac rehabilitation services during the PHE. Additionally, CMS changed the supervision requirements from direct supervision to general supervision, and to allow general supervision throughout hospital outpatient non-surgical extended duration therapeutic services. Similarly, CMS amended the regulation in 42 CFR 415.172 in the March 31, 2020 COVID-19 IFC (85 FR 19230), to state that for the duration of the PHE, the requirement for the presence of a teaching physician during the critical or key portion of a procedure can be met, at a minimum, through direct supervision by interactive telecommunications technology. In other words, the teaching

[154] Centers for Medicare and Medicaid Services: Quality Payment Program, "*COVID-19 Response*," (December 2020). Available online: https://qpp.cms.gov/about/covid19?py=2019
[155] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[156] Ibid.

physician must provide supervision either with physical presence or be present through interactive telecommunications technology during the critical key portion of the service.[157]

CMS has provided flexibility during the PHE to allow physical and occupational therapists who established the maintenance program to delegate the performance of needed maintenance therapy services to therapy assistants, when clinically appropriate. This flexibility is applicable to all provider settings, including institutional providers and therapist private practices, where Part B outpatient therapy services are furnished.[158]

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.[159] 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, however states may not use Medicaid funds to supplement Medicare Part D reimbursement for drugs.[160]

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

[157] Ibid.
[158] Ibid.
[159] 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
[160] 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

subsidy benefit and the cost threshold and cost limit for qualified retiree prescription drug plans eligible for the Retiree Drug Subsidy.[161,162]

Impact of the COVID-19 Public Health Emergency

The CARES Act includes a provision that establishes Part B coverage for COVID-19 vaccines and their administration without any cost-sharing. Provider or supplier's use of drugs or supplies procured or provided by a governmental entity to diagnose or treat patients with known or suspected COVID-19 would not affect Medicare's payment for the service under the applicable prospective payment system or fee schedule. Although Medicare usually doesn't allow payment for services that are paid for by a governmental entity, there is an exception for services furnished as a means of controlling infectious diseases (see 42 CFR § 411.8(b)(4)).[163]

In order to ensure immediate access during the COVID-19 PHE, Medicare will pay for monoclonal antibody products authorized for emergency use to treat COVID-19, furnished consistent with the terms of the EUA, or approved by the Food and Drug Administration (FDA) to treat COVID-19. As of early May 2021, two monoclonal antibody products had active FDA EUAs: one for casirivimab and imdevimab (administered together), and one for bamlanivimab and etesevima (administered together). Medicare will make a payment to the provider or supplier for the monoclonal antibody product to treat COVID-19 (when it is not received by the provider for free) and will make a separate payment for its administration (infusion). Medicare will not provide payment for the monoclonal antibody products to treat COVID-19 that health care providers receive for free, as will be the case upon the product's initial availability in response to the COVID-19 PHE. For monoclonal antibodies furnished through May 5, 2021, the Medicare national average payment rate for the administration was approximately $310 for the infusion of casirivimab and imdevimab (administered together) or bamlanivimab and etesevima (administered together). This preliminary payment rate was based on one hour of infusion and post-infusion monitoring in the hospital outpatient setting. Medicare announced that for monoclonal antibodies furnished on or after May 6, 2021, the national average payment rate will be increased to $450 per administration. In addition, Medicare also announced a new national average payment rate of $750 when providers or suppliers furnish monoclonal antibodies in the home or residence on or after May 6, 2021. If health care providers begin to purchase these monoclonal antibody products, CMS anticipates setting the Medicare payment rate for the product, which will be reasonable cost or 95% of the average wholesale price for many health care providers, consistent with usual vaccine payment methodologies.[164]

[161] 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

[162] 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.

[163] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

[164] Ibid.

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.[165]

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*.[166]

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

Impact of the COVID-19 Public Health Emergency

An IHS outpatient clinic visit for COVID-19 specimen collection and/or laboratory testing qualifies as a billable encounter for purposes of the All-Inclusive Rate, even if the patient does not have a face-to-face encounter with a physician or non-physician practitioner. This is effective for COVID-19 specimen collection and/or diagnostic testing provided on or after March 1, 2020, and for the duration of the COVID-19 PHE.[167]

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, influenza and COVID-19 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. RHCs report the shots and their

[165] 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
[166] 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
[167] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

administration costs on a separate cost report worksheet, not on billed claims.[168] 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 the 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.[169] In the calculation of an 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 an RHC professional service are included in the per-visit payment and are not billed separately from the visit.[170]

The RHC upper payment limit per visit applies to independent RHCs and RHCs that are provider-based to a hospital with 50 or more beds. For CY 2018 the RHC upper payment limit per visit is $83.45 per visit, a one-point four percent (1.4%) increase over CY 2017.[171] The RHC upper payment limit per visit for CY 2019 is $84.70 per visit, a one-point five percent (1.5%) increase over CY 2018.[172,173] For CY 2020, the upper payment per visit is $86.31, representing a one-point nine percent (1.9%) increase from 2019.[174,175] Effective January 1, 2021, the upper payment limit per visit is $87.52, representing a one-point four percent (1.4%) increase from

[168] An RHC can't bill a visit when the practitioner only sees a patient to administer a shot. Instead, the RHC includes shots and their administration on the annual cost report and Medicare reimburses them at cost settlement. Patients pay no Part B deductible or coinsurance for these services.
[169] 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
[170] Ibid.
[171] 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
[172] 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
[173] Calculated by multiplying the Calendar Year 2018 rate by the Medicare Economic Index and reflects a 1.5 percent increase.
[174] 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
[175] Calculated by multiplying the Calendar Year 2019 rate by the Medicare Economic Index and reflects a 1.9 percent increase.

2020. Effective April 1, 2021, the upper payment limit per visit was increased to $100 as authorized under Section 1833(f)(2) of the Act. [176]

Rules for provider-based RHCs in which the hospital has less than 50 beds changed effective April 1, 2021. RHCs tied to hospitals with less than 50 beds as of December 31, 2020 are considered "grandfathered" and have an upper payment limit set based on their AIR. In general, the upper payment limit for these hospitals for 2021 is the greater of their AIR and the statutory payment limit per visit applicable for independent RHCs. In years subsequent to 2021, an RHC's payment limit per visit will be calculated as the previous year upper payment limit per visit increased by the percentage increase in Medicare Economic Index applicable to primary care services furnished as of the first day of such subsequent year. Provider-based RHCs that are new beginning January 1, 2021, and after are subject to the statutory payment limit per visit applicable for independent RHCs.[177]

At the end of the annual cost reporting period, RHCs submit a report to their Medicare Administrative Contractors (MACs). The report includes total allowable costs, total RHC service visits, and other required reporting period information. After reviewing the report, MACs determine a final period rate by dividing allowable costs by the number of actual visits. MACs determine the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. They review interim and final payment rates for productivity, reasonableness, and payment limitations.[178]

In the 2019 Physician Fee Schedule (PFS) Final Rule, CMS finalized a policy that, effective January 1, 2019, RHCs can receive payment for virtual communication services when at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner to a patient who has had an RHC billable visit within the previous year, and both of the following requirements are met:

- The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and
- The medical discussion or remote evaluation does not lead to an RHC visit within the next 24 hours or at the soonest available appointment.

Virtual communication services are considered separate and distinct from telehealth services. Telehealth services are considered a substitute for an in-person visit, whereas virtual communication services are brief discussions with the RHC practitioner to determine if a visit is necessary. If the discussion between the RHC or practitioner and the Medicare beneficiary results in a billable visit, then the usual RHC billing would occur, and the virtual communication

[176] Medicare Learning Network, "*Update to Rural Health Clinic (RHC) Payment Limits*," (Revised May 2021), Available online: https://www.cms.gov/files/document/mm12185.pdf
[177] Ibid.
[178] Medicare Learning Network, *"Rural Health Clinic"* (December 2021). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf

service is not payable.[179] Virtual communication services are billed using HCPCS code G0071 and are paid at $13.69 in CY 2019, $24.76 in CY 2020, and $23.73 in CY 2021.

Impact of the COVID-19 Public Health Emergency

COVID-19 vaccines and their administration are paid the same way influenza and pneumococcal vaccines and their administration are paid in RHCs. Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. The beneficiary coinsurance and deductible are waived.[180] Specimen collection services, on the other hand, are included in the all-inclusive rate for RHCs and are not paid separately, including a specimen collection for COVID-19 testing.[181]

During the COVID-19 PHE, coinsurance and deductible do not apply for certain evaluation and management services when they are related to COVID-19 testing, whether they are furnished in person or via telehealth.[182]

Section 3704 of the CARES Act authorizes RHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. RHCs with this capability can provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE. Distant site telehealth services can be furnished by any health care practitioner working for the RHC within their scope of practice. Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS). Claims for G2025 are paid at the CY2021 rate of $99.45. The CY2022 rate is $97.24.[183]Several codes on the Medicare telehealth list describe telephone (audio only) evaluation and management (E/M) services (CPT codes 99441-99443), and CMS has used waiver authority to allow some behavioral health and patient education services to be furnished using audio-only technology. These services are included on the Medicare telehealth list which can be found at this website:

> https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

[179] Centers for Medicare & Medicaid Services, *"Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions,"* December 2018. Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf
[180] Centers for Medicare & Medicaid Services, *"Rural Health Clinics (RHC) Center,"* Available online: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center
[181] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[182] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[183] Centers for Medicare & Medicaid Services, *"Rural Health Clinics (RHC) Center,"* Available online: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center

Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between the patient and distant site physician or practitioner.[184]

During the COVID-19 PHE, payment for virtual communication services include digital assessment services. Digital assessment services are non-face-to-face, patient-initiated, digital communications using a secure online patient portal. The digital assessment codes that are billable during the COVID-19 PHE are CPT code 99421 (5-10 minutes over a 7-day period), CPT code 99422 (11-20 minutes over a 7-day period), and CPT code 99423 (21 minutes or more over a 7-day period).[185]

RHCs can bill for visiting nursing services furnished by an RN or LPN to homebound individuals under a written plan of treatment in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020 and for the duration of the COVID-19 PHE, the area typically served by the RHC is determined to have a shortage of home health agencies, and no request for this determination is required. RHCs must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.[186]

In general, the requirements for direct supervision have been modified for the duration of the COVID-19 PHE to include the use of a virtual supervisory presence through the use of interactive audio and video telecommunications technology.[187]

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.[188] 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.[189]

[184] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[185] Centers for Medicare & Medicaid Services*, "Rural Health Clinics (RHC) Center,"* Available online: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center
[186] Centers for Medicare & Medicaid Services*, "Rural Health Clinics (RHC) Center,"* Available online: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center
[187] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (December 2021) Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[188] The Physician and Other Practitioner Section of this report provides more information on the Medicare Physician Fee Schedule.
[189] 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

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[190]
- Pregnant by Choice Waiver

[190] 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.