Appendix D: Medicare Reimbursement Methodology

As noted in the 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
Public Health, Federal (Tribal Facilities)	Prospective Payment System
Physician and other Practitioners	Physician Fee Schedule (RBRVS)
Prescription Drugs	Average Sale Price (ASP)
Psychiatric Residential Treatment Facility (PRTF)	N/A
Rural Health Clinic (RHC)	All-inclusive Rate Per Visit with Exceptions
School Based Services	N/A
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 2021 (not including cost sharing paid by beneficiaries) was $4.0 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 and 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 consumer-price index (CPI) for all urban consumers for the 12-month period ending in June of the previous year. Effective January 1, 2023, the Ambulance Inflation Factor (AIF) has been manualized to enable Medicare contractors to accurately determine payment amounts for ambulance services. The AIF for recent years is shown below:

- CY 2018 1.1%
- CY 2019 2.3%
- CY 2020 0.9%
- CY 2021 0.2%
- CY 2022 5.1%
- CY 2023 8.7% [5]

Division FF, section 4103 of the Consolidated Appropriations Act, 2023 extended payment provisions of previous legislation afffecting ambulence fee schedule amounts which include:

- The Bipartisan Budget Act (BBA) of 2018;

[1] MedPAC, "*Ambulance Services Payment System*," (October 2023). Available online: https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_ambulance_FINAL_SEC.pdf
[2] Centers for Medicare and Medicare Services, "Ambulance Fee Schedule Public Use Files," (December 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf
[3] MedPAC, "Ambulance Services Payment System," (October 2023). Available online: https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_ambulance_FINAL_SEC.pdf
[4] A loaded mile is a mile during which a Medicare beneficiary is transported in an ambulance.
[5] CMS Manual System, "Pub 100-04 Medicare Claims Processing," (2023). Available online: https://www.cms.gov/files/document/r11642cp.pdf

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

Division FF, section 4103 of the Consolidated Appropriations Act, 2023 includes an extension of the temporary add-on payment under section 1834 (l)(12)(A) of the Act that were set to expire on December 31, 2022. These add-on payments have been extended through December 31, 2024. The temporary add-on payment includes a 22.6% increase in the base rate for ground ambulance transports that originate in an area that's within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus).

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 seventeen (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 began entering data into the tool in calendar year 2022. The survey collects detailed information on ground ambulance provider and supplier characteristics including service areas, service volume, costs, and revenue through a data collection instrument.[9]

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."[10] 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.

[6] Centers for Medicare and Medicaid Services, *"Ambulance Fee Schedule Public Use Files."* (January 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.html

[7] Centers for Medicare and Medicaid Services, *"Ambulance Fee Schedule Public Use Files."* (January 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.html

[8] MedPAC, "*Ambulance Services Payment System*," (October 2023). Available online: MedPAC_Payment_Basics_23_ambulance_FINAL_SEC.pdf

[9] Centers for Medicare and Medicaid Services, "Federal Register Vol. 87 FR 69404," (November 2022) Available online: https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

[10] Wyoming Department of Health, "*Ambulatory Surgical Center*," (2023). 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.[11] 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.[12]

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.[13] As of November 2, 2018, CMS updated the ASC payment rates using the productivity-adjusted hospital market basket rather than the CPI-U for CY 2019 through CY 2023.[14] Due to the impact of the PHE, CMS extended the five-year interim period an additional two years — through CY 2024 and CY 2025. The extension will allow CMS to gather additional claims data to more accurately analyze whether the application of the hospital market basket update to the ASC payment system affects the migration of services from the hospital setting to the ASC setting.[15]

By using the hospital market basket, CMS updated ASC rates for:

- CY 2020, CMS increased the ASC rates 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.
- 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.[16]
- CY 2022, CMS increased the ASC rate by 2 percent (2.0%) based on the basket increase of two-point seven percent (2.7%) and the zero-point seven percent (0.7%) mandated productivity reduction by the *Affordable Care Act* – totaling a zero-point three percent (0.3%) reduction from the proposed rule.[17]

[11] Centers for Medicare and Medicaid Services, "*Ambulatory Surgical Center Payment*," (February 2023). Available online: https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment

[12] 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

[13] 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

[14] Centers for Medicare and Medicaid Services, "*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

[15] Centers for Medicare and Medicaid Services, "*CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1786-FC),"* (December 2023). Available online: https://www.cms.gov/newsroom/fact-sheets/cy-2024-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

[16] 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

[17] Centers for Medicare and Medicaid Services, *"CY 2022 Medicare Hospital Outpatient PPS and ASC Payment System Final Rule,* (2021). Available online: https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

- CY 2023, CMS increased a productivity-adjusted hospital market basket update factor to the ASC rates for CY 2023 of three-point eight percent (3.8%) which is based on the hospital market basket percentage increase of four point one percent (4.1%), reduced by 0.3 percentage point for the productivity adjustment.[18]
- CY 2024, CMS increased the ASC rates for hospitals that meet the quality reporting requirements by three-point one percent (3.1%) which is based on the projected hospital market basket percentage increase of three point three (3.3%), reduced by a 0.2 percentage point for the productivity adjustment.

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. [19] Furthermore, CMS makes a geographic payment adjustment for covered surgical procedures and certain covered ancillary services using the pre-floor and pre-reclassified hospital wage index values, with a labor-related factor of 50 percent. CMS makes an additional adjustment when the ASC furnishes multiple surgical procedures in the same encounter or when ASC personnel discontinue procedures prior to their initiation or the administration of anesthesia.[20]

A device-intensive procedure policy for ASCs has been finalized to ensure ASC rates are used to calculate the device offset percentage and not hospital and outpatient departments (HOPD) rates. The policy change designates that "any procedure for which the device cost is thirty percent (30%) of the overall ASC procedure rate will receive device-intensive status." In addition, a device with an HOPD device-intensive status will also be device-intensive in the ASC setting. Beginning CY 2022, "if a procedure is assigned device-intensive status for HOPDs but has a device offset percentage below the device-intensive threshold under the standard ASC rate-setting methodology, the procedure will be assigned device-intensive status under the ASC payment system with a default device offset percentage of thirty one percent (31%)."[21]

To address patient access issues for dental services under anesthesia in the ASC setting, beginning CY 2024, CMS added 26 separately payable dental surgical procedures to the ASC Covered Procedures List and 78 ancillary dental services to the list of covered ancillary services.

[18] Centers for Medicare and Medicaid Services, "*CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC),"* (December 2023). Available online: CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC) | CMS

[19] Centers for Medicare and Medicaid Services, "*Medicare Payment Systems*," (January 2023). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Ambulatory

[20] Health and Human Services, "*MLN Booklet: Ambulatory Surgical Center Payment System*," (December 2023). Available online: Ambulatory Surgical Center Payment System (hhs.gov)

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

Behavioral Health

Medicare covers inpatient mental health services under Part A, and under Part B it covers outpatient mental health services, including evaluation and visits with a mental health provider. Medicare Part B covers mental health services and visits with these types of health professionals:

- Psychiatrist or other doctor
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician assistant
- Marriage & family therapists (effective January 1, 2024)
- Mental health counselors (effective January 1, 2024)

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. Advanced practitioner professionals (APPs) including nurse practitioners, physician assistants and clinical nurse specialists are paid at eighty-five percent (85%) of the amount that a physician is paid under the Medicare physician fee schedule. Clinical social workers are paid at seventy-five percent (75%) of the amount that a clinical psychologist is paid. [22,23]

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.[24,25,26] 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.[27]

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-

[22] Please see the Physician and Other Practitioner section for more information on the Medicare Physician Fee Schedule.
[23] Centers for Medicare and Medicaid Services, "*Physician Fee Schedule,"* (2023). Available online: https://www.cms.gov/medicare/payment/fee-schedules/physician
[24] Centers for Medicare and Medicaid Services, "*Mental Health Care (Inpatient),"* Available online: https://www.medicare.gov/coverage/inpatient-mental-health-care.html
[25] Centers for Medicare and Medicaid Services, *"Mental Health Care (Outpatient),"* Available online: https://www.medicare.gov/coverage/outpatient-mental-health-care.html
[26] 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
[27] 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

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 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.[28]

Effective CY 2022, section 123 of the Consolidated Appropriations Act (CAA) removed the geographic restrictions for telehealth services and added the home of the beneficiary as a permissible originating site for telehealth services furnished for the purposes of diagnosis, evaluation, or treatment of mental health. Within six months prior to the first telehealth visit, there must be an in-person, non-telehealth service with a physician or practitioner and there must be an in-person visit at least every twelve (12) months thereafter. Exceptions may be made for limited circumstances if properly noted in the beneficiary's medical records. CMS has clarified that mental health services can include services for substance use disorder treatment.[29]

CMS issued the CY 2024 Physician Fee Schedule (PFS) final rule (CMS-1784-F) that announced significant policy changes that are effective January 1, 2024 including the implementation of the Healthcare Common Procedure Coding System (HCPCS) G2211, an add-on for services associated with complex patient care; reimbursement for health related social needs services; and the maintenance of several telehealth payment policies until the end of 2024. Some highlights include that the final rule:

- Recognizes Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) as practitioners who may enroll with Medicare and bill independently for services furnished for the diagnosis and treatment of mental illnesses. Additionally, this includes addiction counselors that meet all the applicable requirements to be MHCs to enroll in Medicare as MHCs.
- Makes corresponding changes to Behavioral Health Integration codes to allow MHCs and MFTs to provide integrated behavioral health care as part of primary care settings.
- Allow the Health Behavior Assessment and Intervention (HBAI) services to be billed by clinical social workers, MHCs and MFTs, in addition to clinical psychologists. HBAI codes are used to identify the psychological, behavioral, emotional, cognitive and social factors included in the treatment of physical health problems.
- Establishes new HCPCS codes for psychotherapy for crisis services (HCPCS codes G0017 and G0018) that are furnished in an applicable site of service (any place of

[28] Centers for Medicare and Medicaid Services. "*Medicare Payment Systems*," (January 2023). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Ambulatory

[29] Centers for Medicare and Medicaid Services, *"CMS finalizes mental health and substance use disorder parity rule for Medicaid and CHIP,"* (2016). Available online: https://www.cms.gov/newsroom/press-releases/cms-finalizes-mental-health-and-substance-use-disorder-parity-rule-medicaid-and-chip

service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting). Payment for these psychotherapy for crisis services is equal to one hundred and fifty percent (150%) of the fee schedule amount for services furnished in non-facility sites of service.

- Aligns with the CAA 2023 to extend certain telehealth policies through December 31, 2024.[30]

Dental

In general, Medicare does not reimburse dental services for the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, except for inpatient hospital services connected to dental services when the patient requires hospitalization due to one of these reasons:

- The patient's underlying medical condition and clinical status
- The severity of the dental procedure

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.[31]

[30] Federal Register, *"CMS-1784-F,"* (December 2023). Available online: https://public-inspection.federalregister.gov/2023-24184.pdf

[31] Centers for Medicare and Medicaid Services, "*Medicare Dental Coverage,*" (April 2023). Available online: http://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html

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.[32] Medicare used to have a national Competitive Bidding Program (CBP) for various DMEPOS services, but all contracts expired on December 31, 2018.[33] As of January 1, 2019, there was a temporary gap in this program until December 31, 2020.[34] 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.[35] 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.[36] 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.[37] 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

[32] Centers for Medicare and Medicaid Services, "*DMEPOS Fee Schedule*," (2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

[33] Centers for Medicare and Medicaid Services, "*DMEPOS Competitive Bidding*," (May 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html

[34] 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

[35] 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/

[36] Centers for Medicare and Medicaid Services, "*DMEPOS Competitive Bidding*," (May 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html

[37] 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

update factor does not apply to product categories included in the Round 2021 Competitive Bidding Program.[38]

Effective January 2022, the Medicare DMEPOS Fee Schedule will increase by a net total of five-point one percent (5.1%), as a result of a five-point four percent (5.4%) CPI-U increase and a negative zero-point three percent (-0.3%) productivity adjustment.[39]

Section 4139 of the Consolidated Appropriations Act (CAA), 2023 requires the fee schedule amounts for items and services provided in non-rural contiguous non-competitive bidding areas (CBAs) be based on a blend of seventy-five (75%) of the adjusted fee schedule amounts and twenty-five percent (25%) of the unadjusted fee schedule amounts for claims with dates of service for the remainder of the COVID-19 public health emergency (PHE) (which ended on May 11, 2023). Starting January 1, 2024, the fee schedule amounts for items and services provided in non-rural contiguous non-CBAs is based on one hundred percent (100%) of the fee schedule amounts. In addition, for CY 2024, there is an update factor of two-point six percent (2.6%) to certain DMEPOS fee schedule amounts that aren't adjusted using information from CBPs. For CY 2024, there is a net increase of two-point six percent (2.6%) which includes reducing the CPI-U increase of three percent (3%) by the zero-point four percent (0.4%) increase in a Total Factor Productivity.

Effective January 1, 2024, the DMEPOS fee schedule file will include national payment amounts for lymphedema compression treatment items. Starting January 1, 2024, national payment amounts for lymphedema compression treatment items are on the DMEPOS fee schedule file for the new HCPCS codes.[40]

DMEPOS Competitive Bidding Program

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

[38] 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

[39] Centers for Medicare and Medicaid Services, *"Calendar Year 2022 Update for DMEPOS Fee Schedule,"* (2021). Available online: https://www.cms.gov/files/document/mm12521-calendar-year-2022-update-durable-medical-equipment-prosthetics-orthotics-and-supplies.pdf

[40] CMS.gov, "DMEPOS Fee Schedule: CY 2024 Update," (December 2023). Available online: MM13463 - DMEPOS Fee Schedule: CY 2024 Update (cms.gov)

Starting January 1, 2024, there will be a temporary gap period for the DMEPOS CBP. During the temporary gap period, Medicare-enrolled DMEPOS suppliers may furnish DMEPOS items and services to patients. The payment rules include:

- Adjusted fees in former competitive bidding areas (CBAs) are based on one hundred percent (100%) of the single payment amount for the CBA increased by the projected percentage change in the Consumer Price Index for All Urban Consumers (CPI-U) from January 2023 - January 2024
- Adjusted fees in non-CBAs are based on fully adjusted rates per the applicable methodology under 42 CFR 414.210(g)[41]

All DMEPOS Competitive Bidding Program Round 2021 Contracts for Off-the-Shelf (OTS) back braces and for OTS knee braces expired on December 31, 2023. Starting January 1, 2024, there will be a temporary gap period for the DMEPOS CBP. CMS will start bidding for the next round of the DMEPOS CBP after they complete the formal public notice and comment rulemaking process and implement the new changes.[42]

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. Beginning January 1, 2024, there will be a temporary gap period in the competitive bidding program. 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.[43]

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

[41] CMS.gov, "DMEPOS Competitive Bidding Program: Temporary Gap Period," (December 2023). Available online: https://www.cms.gov/files/document/mln764994-dmepos-competitive-bidding-program-temporary-gap-period.pdf
[42] CMS.gov, "DMEPOS Competitive Bidding Program: Temporary Gap Period (December 2023). Available online: MLN764994 - DMEPOS Competitive Bidding Program: Temporary Gap Period (cms.gov)
[43] Centers for Medicare and Medicaid Services, "*DMEPOS Competitive Bidding*," (May 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html

adjusted fee schedule amounts (adjusted based on information from the CBP) and fifty percent (50%) of the higher historic, unadjusted fee schedule amounts.[44]

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.[45]

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

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

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

There is a Medicare training add-on payment that is computed by using the national average hourly wage for nurses from the Bureau of Labor Statistics. The payment accounts for nursing time for each training treatment that is furnished, and 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.

[44] Centers for Medicare and Medicaid Services, "*COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,"* (April 2023). Available online: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

[45] Centers for Medicare and Medicaid Services, *"ESRD PPS Consolidated Billing,"* (January 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html

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. 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.

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 substantially improves, relative to renal dialysis services previously available, the diagnosis or treatment of Medicare beneficiaries.[46]

The ESRD PPS base rates for the last few years were:

- CY 2018: $232.37
- CY 2019: $235.27
- CY 2020: $239.33
- CY 2021: $253.13
- CY 2022: $257.90
- CY 2023: $265.57

On October 27, 2023, CMS issued a final rule that updates payment rates and policies under the ESRD PPS for renal dialysis services furnished to Medicare beneficiaries on or after January 1, 2024.

For CY 2024, ESRD PPS base rate was increased to $271.02, increasing total payments to ESRD facilities by approximately two-point one percent (2.1%). In addition, the rate includes a payment adjustment that will increase payment for certain new renal dialysis drugs and biological products after the Transitional Drug Add-on Payment Adjustment (TDAPA) period ends to ensure payment is not a barrier to accessing innovative treatments for Medicare ESRD beneficiaries.

[46] Centers for Medicare and Medicaid Services, "*End-Stage Renal Disease Prospective Payment System (PPS) Overview*," (October 2022). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html

Furthermore, for CY 2024 through CY 2026, there is a new transitional add-on pediatric ESRD dialysis payment which is expected to promote equitable and accurate payments, since treatment for the pediatric ESRD population tends to be especially complex and costly.[47]

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.[48] Under the FQHC PPS system, Medicare pays claims at eighty percent (80%) of the lesser of the FQHC charges based on their payment codes or the FQHC PPS rate.[49]

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*. CMS annually updates the FQHC PPS base payment rate using the FQHC market basket. In CY 2022, the FQHC PPS GAFs were updated in order to be consistent with the statutory requirements."[50] 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.[51,52,53]

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

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

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[47] CMS.gov, "Calendar Year 2024 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) Final Rule (CMS-1782-F), (December 2023). Available online: Calendar Year 2024 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) Final Rule (CMS-1782-F) | CMS

[48] Centers for Medicare and Medicaid Services, "*FQHC PPS*," (December 2021). Available online: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Index.html

[49] Centers for Medicare and 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

[50] CMS Manual System, *"PUB 100-04 Medicare Claims Processing Transmittal 11057,"* (2021). Available online: https://www.cms.gov/files/document/r11057cp.pdf

[51] Centers for Medicare and Medicaid Services, "*Medicare Benefit Policy Manual Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services*," (January 2023). Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

[52] Centers for Medicare and Medicaid Services, *"Update to the Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) – Recurring File Updates,"* (May 2021). Available online: https://www.hhs.gov/guidance/document/update-federally-qualified-health-centers-fqhc-prospective-payment-system-pps-recurring

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 was 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 was $166.60, representing a one-point nine percent (1.9%) payment increase above the 2016 base payment rate of $163.49.[54] 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.[55]

For CY 2022, the FQHC PPS base payment rate was updated using the 2017 base year for the FQHC market basket. The 2017-based FQHC market basket update for CY 2022 is two-point one percent (2.1%). The final CY 2022 FQHC base payment rate was $180.16,[56] the final CY 2023 FQHC base payment rate was $187.19[57], and the final CY 2024 FQHC base payment rate is $195.99.[58]

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.

[54] Centers for Medicare and 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

[55] Centers for Medicare and 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

[56] Centers for Medicare and Medicaid Services, *"Pub 100-04 Medicare Claims Processing Transmittal 11057,"* (2021). Available online: https://www.cms.gov/files/document/r11057cp.pdf

[57] Centers for Medicare and Medicaid Services, *"Pub 100-04 Medicare Claims Processing Transmittal 11677,"* (2022). Available online: https://www.cms.gov/files/document/r11677cp.pdf

[58] Centers for Medicare and Medicaid Services, *"Regulations and Guidance Transmittal R12267CP,"* (2022). Available online: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2023-transmittals/r12267cp

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 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.[59] Virtual communication services are billed using HCPCS code G0071 and were paid at $23.14 in CY 2023.[60]

Beginning on or after January 1, 2022, RHCs and FQHCs can report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way in-person visits are reported and reimbursed, including audio-only visits when the beneficiary is not capable of or does not consent to, the use of video technology. Payment under HCPCS code G2025 will no longer apply to mental health visits furnished via telehealth. This payment policy for mental health visits was made permanent for RHCs and FQHCs in the CY 2022 PFS final rule.[61]

Home Health

Medicare pays home health agencies (HHAs) through a prospective payment system (PPS) that adjusts payment for the health condition and care needs of the beneficiary using a case-mix adjustment. Payments are also adjusted for geographic differences in local wages. In addition, for beneficiaries who incur unusually large costs, additional payments will be made to the 30-day case-mix adjusted period and associated payments. Starting in CY 2020, the home health PPS provides payments for each 30-day episode of care, as opposed to the historical 60-day episode of care. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin, with no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. [62]

In November 2023, CMS issued a final rule (CMS-1780-F) that finalizes routine updates to the home health payment rates for CY 2024, in accordance with existing statutory and regulatory requirements. A summary of key components of this final rule includes:

- discusses comments received regarding access to home health aide services.
- implements home health payment-related changes.
- rebases and revises the home health market basket and revises the labor-related share.
- codifies statutory requirements for disposable negative pressure wound therapy; and

[59] Centers for Medicare and 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

[60] Centers for Medicare and Medicaid Services, *"Virtual Communication Services in RHCs and FQHCs FAQs,"* (November 2022). Available online: https://www.cms.gov/files/document/se20016-new-expanded-flexibilities-rhcs-fqhcs-during-covid-19-phe.pdf

[61] Federal Register, "CY 2022 PFS Final Rule," (January 2024). Available online: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf

[62] Centers for Medicare and Medicaid Services, "*Home Health PPS*," (December 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html

- implements the new items and services payment for the home intravenous immune globulin benefit.[63]

The CY 2024 Medicare payments for home health PPS have been updated and include an estimated increase in aggregate of $140 million (0.8 percent), compared to CY 2023. The increase reflects the effects of the final CY 2024 home health payment update percentage of three percent (3%) ($525 million increase), an estimated two point six percent (2.6%) decrease that reflects the effects of the permanent behavior adjustment ($455 million decrease), and an estimated zero point four percent (0.4%) increase that reflects the effects of an updated fixed-dollar loss ratio used in determining outlier payments ($70 million increase).[64] In addition, CMS is also finalizing its proposals to rebase and revise the home health market basket; revise the labor-related share; recalibrate the PDGM case-mix weights; and update the low utilization payment adjustment (LUPA) thresholds, functional impairment levels, and comorbidity adjustment subgroups for CY 2024.[65]

In 2010, Section 3131(a) of the *Affordable Care Act* was signed into law mandating 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.[66]

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

[63] Center for Medicare and Medicaid Services, "*CMS-1780-F,"* (December 2023). Available online: https://www.cms.gov/medicare/medicare-fee-service-payment/homehealthpps/home-health-prospective-payment-system/cms-1780-f

[64] Federal Register, *"Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements,"* (December 2023). Available online: https://www.govinfo.gov/content/pkg/FR-2023-11-13/pdf/2023-24455.pdf

[65] Centers for Medicare and Medicaid Services, *"Fact Sheet: Calendar Year (CY) 2024 Home Health Prospective Payment System Final Rule (CMS-1780-F),"* (December 2023). Available online: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-home-health-prospective-payment-system-final-rule-cms-1780-f

[66] Congress, *"Public Law 111-148-Mar. 23, 2010,"* (December 2023). Available online: https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf

furnished during a period to offset the increase in payments resulting in the application of this section of the statute.[67]

The CMS Final Rule effective January 1, 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.

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

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.[68]

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.[69]

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-

[67] Centers for Medicare and Medicaid Services, "*CMS Manual System Pub 100-04 Medicare Claims Processing*, *Transmittal 3624,"* (December 2023). Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3624CP.pdf

[68] Federal Register*, "Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements,"* (December 2023). Available online: https://www.federalregister.gov/documents/2015/11/05/2015-27931/medicare-and-medicaid-programs-cy-2016-home-health-prospective-payment-system-rate-update-home

[69] 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

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.[70]

CMS estimates CY 2022 Medicare payments to HHAs will increase by $570 million (3.2%), as a result of the effects of the CY 2022 home health payment update percentage of two point six percent (2.6%) ($465 million increase), an estimated zero point seven percent (0.7%) increase that reflects the effects of the updated fixed-dollar loss ratio ($125 million increase), and an estimated zero point one percent (0.1%) decrease in payments due to the changes in rural add-on percentages for CY 2022 ($20 million decrease). [71]

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.[72] The 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 two (2) visits for each group.[73]

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

[70] Centers for Medicare and Medicaid Services, "*Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020*," (May 2021). Available online: https://www.hhs.gov/guidance/document/home-health-prospective-payment-system-hh-pps-rate-update-calendar-year-cy-2020

[71] Centers for Medicare and Medicaid Services, "*86 FR 62240,"* (November 2021). Available online: https://www.federalregister.gov/documents/2021/11/09/2021-23993/medicare-and-medicaid-programs-cy-2022-home-health-prospective-payment-system-rate-update-home

[72] Centers for Medicare and Medicaid Services, "*Home Health PPS*," (December 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html

[73] Centers for Medicare and Medicaid Services, "*Medicare Benefit Policy Manual Chapter 7 - Home Health Services*," (June 2022). Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

services, and home health aide service needs, at the beginning of the 60-day[74] 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.[75]

CMS' policy is to annually recalibrate the case-mix weights and LUPA thresholds using the most complete utilization data available at the time of rulemaking. CMS is finalizing its proposal to recalibrate the case-mix weights (including the functional levels and comorbidity adjustment subgroups) and LUPA thresholds using CY 2022 data to more accurately pay for the types of patients serve.[76]

Outlier Payments

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

[74] 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).

[75] Centers for Medicare and Medicaid Services, "*Home Health PPS*," (December 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html

[76] Centers for Medicare and Medicaid Services, *"Calendar Year (CY) 2024 Home Health Prospective Payment System Final Rule (CMS-1780-F) Fact Sheet,"* (December 2023). Available online: Calendar Year (CY) 2024 Home Health Prospective Payment System Final Rule (CMS-1780-F) | CMS

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.

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.[77]

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 sixty (60) days of hospice care with a reduced payment rate for days sixty-one (61) and over. Additionally, starting January 1, 2016, a service intensity add-on (SIA) payment was 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:

[77] Centers for Medicare and Medicaid Services, *"Calendar Year (CY) 2024 Home Health Prospective Payment System Final Rule (CMS-1780-F) Fact Sheet,"* (December 2023). Available online: Calendar Year (CY) 2024 Home Health Prospective Payment System Final Rule (CMS-1780-F) | CMS

[78] Centers for Medicare and Medicaid Services, "*Hospice Payment System"* (March 2022). Available online: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospice

- 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 (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]

For FY 2022, hospice payment update percentage was a two percent (2%) increase ($480 million) in payment, and the aggregate cap amount was $31,297.61. The rate change is a result of the two-point seven percent (2.7%) market basket increase reduced by a zero-point seven percentage (0.7%) point productivity adjustment. Notably, hospice providers who do not meet quality metrics will receive a percentage point reduction in their annual update. [83]

The FY 2023 hospice payment update percentage was three-point eight percent (3.8%) which is an estimated increase of $825 million in payments from FY 2022.[84]

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[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, "*CMS-1754-F,"* (2021). Available online: https://www.federalregister.gov/public-inspection/current

[84] Centers for Medicare and Medicaid Services, *"Fiscal Year (FY) 2023 Hospice Payment Rate Update Final Rule (CMS-1773-F),"* (December 2023). Available online: https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-

The FY 2024 hospice payment update percentage is three-point one percent (3.1%) which is an estimated increase of $780 million in payments from FY 2023. The hospice cap amount for FY 2024 is $33,494.01. Beginning in FY 2024 and for each subsequent year, hospices that fail to meet quality reporting requirements receive a four (4) percentage point reduction to the annual hospice payment update percentage increase for the year.[85]

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.[86]

In FY 2023, rates for general acute hospitals that successfully participated in the Hospital Inpatient Quality Reporting (IQR) Program and implemented meaningful electronic health records (EHR) increased approximately three-point eight percent (3.8%). The rate update is a reflection of the four-point one percent (4.1%) market basket update, reduced by a zero-point three percentage point (0.3) productivity adjustment. The final FY 2023 IPPS market basket growth rate of four-point percent (4.1%) would be the highest market basket update implemented in an IPPS final rule since FY 1998.

Although the PHE has ended and COVID-19 vaccination rates have increased, due to the expectation of future variants to the COVID-19 virus and the likelihood that COVID-19 related hospitalizations will continue in the future – inpatient hospital rates were calculated for FY 2023 using FY 2021 hospital utilization data with some modifications to the outlier rate calculation methodology.[87]

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 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

2023-hospice-payment-rate-update-final-rule-cms-1773-f#:~:text=FY%202023%20Routine%20Annual%20Rate%20Setting%20Changes&text=The%20hospice%20payment%20update%20includes,%2431%2C297.61%20increased%20by%203.8%25).

[85] Centers for Medicare and Medicaid Services, *"Fiscal Year 2024 Hospice Payment Rate Update Final Rule (CMS-1787-F)*," (December 2023). Available online: https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2024-hospice-payment-rate-update-final-rule-cms-1787-f

[86] 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

[87] Centers for Medicare and Medicaid Services, *CMS-1771- F, (2022) https://www.federalregister.gov/documents/2022/08/10/2022-16472/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the*

principal diagnosis and up to twenty-four (24) secondary diagnoses along with up to twenty-five (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.[88]

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.[89]

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).[90] 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.

[88] Centers for Medicare and Medicaid Services, MS-DRG Classifications and Software (2024). Available online: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software

[89] Centers for Medicare and Medicaid Services, Acute Inpatient PPS (2023). Available online: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps

[90] Centers for Medicare and Medicaid Services, "*Actual Regulation Market Basket Updates*." (April 2023). 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.[91]

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 (SSI), and the percentage of total inpatient days for patients eligible for Medicaid but not Medicare Part A[92,93] A hospital must have a minimum DSH percentage, which differs across hospital groups, to qualify for DSH payments. Urban hospitals with more than one hundred (100) beds have a lower threshold than hospitals in rural areas with less than one hundred (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.[94]

Effective April 24, 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.[95]

Medicare Disproportionate Share Hospital Payments

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

[92] Centers for Medicare and Medicaid Services, *“Disproportionate Share Hospital,”* (June 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInPatientPPS/dsh

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

[94] Centers for Medicare and Medicaid Services, “*Disproportionate Share Hospital,”* (January 2023). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Disproportionate_Share_Hospital.pdf

[95] Centers for Medicare and Medicaid Services, *“Disproportionate Share Hospital,”* (June 2023). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInPatientPPS/dsh

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

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. In FY 2022 CMS calculated each hospital's uncompensated care payments, except for IHS, Tribal, and Puerto Rico hospitals, using the most recent available single year of audited Worksheet S-10 data. For FY 2023, CMS used a multiyear averaging methodology to determine eligible hospital's uncompensated care payments. Specifically for FY 2023, CMS used a 2-year average of audited data on uncompensated care costs from Worksheet-10 from FYs 2018 and 2019. This calculation included all eligible hospitals, including IHS, Tribal, and Puerto Rico hospitals.[96]

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

- Seventy-five percent (75%) of the total DSH payments that would otherwise be made under the old DSH methodology (Section 1886(d)(5)(F) of the Social Security Act),
- One (1) minus the percent change in the percent of individuals who are uninsured.
- A hospital's amount of uncompensated care relative to the amount of uncompensated care for all DSH hospitals expressed as a percentage.[97]

[96] Centers for Medicare and Medicaid Services, Medicare Learning Network, *"Medicare Disproportionate Share Hospital Fact Sheet,"* (January 2023). Available online : https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/disproportionate_share_hospital.pdf

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

Indirect Medical Education Payments

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.[98]

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.[99]

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

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

[99] Centers for Medicare and 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

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).[100]

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.[101] 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.[102,103] 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%).[104] These reductions are used to

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

[101] Centers for Medicare and Medicaid Services, "*Hospital Quality Initiative,"* (October 2022). Available online: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/index.html

[102] 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

[103] Centers for Medicare and Medicaid Services, *"Hospital Inpatient Quality Reporting Program,"* (December 2021). Available online: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

[104] Centers for Medicare and Medicaid Services, "*Hospital Value-Based Purchasing Program,"* (March 2023). Available online: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-

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 and subsequent years are shown below:

- Clinical Outcomes (25 percent)
- Person and Community Engagement (25 percent)
- Safety (25 percent)
- Efficiency and Cost Reduction (25 percent)[105]

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.[106]

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

[105] Centers for Medicare and Medicaid Services, *"Linking Quality to Payment,"* Available online: https://data.cms.gov/provider-data/topics/hospitals/linking-quality-to-payment

[106] 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

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.[107]

Hospital Readmissions

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)[108]

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).[109] 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* 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 one (1) concluded on December 31, 2016.

- *Model 2 - Retrospective Acute Care Hospital Stay Plus Post-Acute Care* includes the inpatient hospitalization, physician, and post-discharge services. In this BPCI model,

[107] 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
[108] 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
[109] Center for Medicare and Medicaid Innovation, "*Bundled Payments for Care Improvement Initiative Frequently Asked Questions,"* Available online: http://innovation.cms.gov/Files/x/Bundled-Payments-FAQ.pdf

Medicare will continue to make fee-for-service payments to participants for Model 2 episodes of care while reconciling the total cost of care for the episode against a bundled payment amount target price set by CMS. A payment or recoupment is later made by Medicare based on the aggregate performance compared to the target price. The episode will end either 30, 60, or 90 days after hospital discharge. Participants can select up to forty-eight (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.

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

- *Model 4 - Acute Care Hospital Stay Only* includes the inpatient hospitalization, physician, and related readmission services for thirty (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 forty-eight (48) different clinical condition episodes with Medicare paying participants a prospectively determined amount.[110]

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.[111] 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, 2025. The third cohort started on January 1, 2024. [112]

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)

[110] Centers for Medicare and Medicaid Services, "*Bundled Payments for Care Improvement (BCPI) Initiative: General Information"*. Available online: https://www.cms.gov/priorities/innovation/innovation-models/bundled-payments
[111] 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
[112] Centers for Medicare and Medicaid Services, "BPCI Advanced," Available online: https://innovation.cms.gov/innovation-models/bpci-advanced

- Qualifies as an Advanced Alternative Payment Model (AAPM)
- 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.[113]

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.[114] 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.

[113] Centers for Medicare and Medicaid Services, "BPCI Advanced," Available online: https://innovation.cms.gov/innovation-models/bpci-advanced

[114] Centers for Medicare and Medicaid Services, "*Hospital Outpatient Prospective Payment System*," (April 2023). Available online: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps

- Transitional outpatient payments for cancer hospitals and children's hospitals.
- A rural adjustment (currently an increased payment of seven-point one percent (7.1%)) for most services furnished by Sole Community Hospitals (SCHs), which includes Essential Access Community Hospitals located in rural areas (effective January 1, 2006).
- 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.

The CY 2023 rates for hospitals that meet the applicable quality reporting requirements is three-point eight percent (3.8%). The update reflects a four-point one percent (4.1%) hospital market basket increase, reduced by zero-point three percentage points (0.3) for the productivity adjustment.[115]

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
- 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 2022 was $130 and $135 for CY 2023.[116] 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.

[115] Centers for Medicare and Medicaid Services, "*CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period,"* (November 2022). Available online: https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-2

[116] Centers for Medicare and Medicaid Services, *Documentation Citation 87 FR 71748*, (2022). Available online: https://www.federalregister.gov/documents/2021/11/16/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

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[117]

Price Transparency of Hospital Standard Charges

To ensure consumers have the information they need to make fully informed decisions regarding their health care, CMS is implementing policies to enhance hospital price transparency. Effective January 2022, CMS will enforce hospital price transparency compliance through: (1) increasing Civil Monetary Penalties (CMP) for larger hospitals; (2) deeming state forensic hospitals as having met requirements; (3) prohibiting additional specific barriers to access to the machine-readable file.[118]

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.[119] Medicare does not cover services provided in an ICF/IID.[120]

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

[117] Medicare MLN Education Tool, *"Medicare Payment Systems,"* Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html
[118] Centers for Medicare and Medicaid Services, *CMS-1753-FC,* (2021). Available online: https://www.federalregister.gov/documents/2021/11/16/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment
[119] 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
[120] 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.[121] 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.)[122]

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.[123] 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.[124]

Effective CY 2022, under Section 1833(h)(7) of the Social Security Act, a pap smear test requires payment at the lesser of the local fee or the National Limitation Amount, but not less than a national minimum payment[125] amount. However, payment may also not exceed the actual charge. The annual reasonable charge update for all other laboratory services is nine-point one percent (9.1%).[126]

Laboratory services rendered in an outpatient hospital setting are paid on a reasonable charge basis, rather than the fee schedule.

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 one hundred (100) days of "skilled nursing"

[121] Centers for Medicare and Medicaid Services, *"HealthCare.gov Enrollment Exceeds 15 Million, Surpassing Previous Years' Milestones,"* 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

[122] Centers for Medicare and Medicaid Services, "*Clinical Laboratory Fee Schedule*," Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched

[123] 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

[124] Centers for Medicare and Medicaid Services, "*Clinical Laboratory Fee Schedule*," Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched

[125] The CY 2023 national minimum payment amount is $17.31 (This value reflects the CY 2022 national minimum payment with a 8.8% increase or $15.92 times 1.087.) The affected codes for the national minimum payment amount are: 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, Q0111, Q0115, and P3000).

[126] Centers for Medicare and Medicaid Services, "R11881CP*,"* (February 2023). Available online: https://www.cms.gov/files/document/mm12558-calendar-year-cy-2022-annual-update-clinical-laboratory-fee-schedule-and-laboratory-services.pdf

care per spell of illness at a Skilled Nursing Facility (SNF). However, the conditions for obtaining Medicare coverage of a nursing home stay are quite stringent: the Medicare beneficiary must enter the nursing home no more than thirty (30) days after a hospital stay that itself lasted for at least three (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 2022 NHEA data, Medicare provided about twenty-two percent (22%) of total payments to nursing facilities nationally.[127]

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.[128]

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.[129]

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 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

[127] Centers for Medicare and Medicaid Services, "*National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2022."* (December 2023). Available online: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

[128] Centers for Medicare and Medicaid Services, *"Medicare Coverage for Skilled Nursing Facility Care,"* Available online: https://www.medicare.gov/Pubs/pdf/10153-Medicare-Skilled-Nursing-Facility-Care.pdf

[129] Centers for Medicare and Medicaid Services, "*Skilled Nursing Facility Prospective Payment System,"* (April 2023). Available online: https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps

"Variable Per Diem (VPD) adjustment" that adjusts the per diem rate over the course of the stay.[130]

As a result of final rule payment policy adjustments, CMS estimates an approximate $904 million increase in Medicare Part A payments to SNFs in FY 2023. This estimate reflects a five-point one percent (5.1%) increase to the payment rates based on a three-point nine percent (3.9%) SNF market basket update, plus a one-point five percentage point (1.5%) forecast error adjustment and less a zero-point three percentage point (0.3%) productivity adjustment.

To improve payment accuracy, the 2018-based SNF market basket was used to update the PPS payment rates, instead of the previous 2014-based SNF market basket. [131]

Figure B.2: SNF PPS Rate Factors[132]

Skilled Nursing Facility PPS	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23
Market Basket Update	2.6	2.8	2.8	2.2	2.7	3.9
Productivity Adjustment	0.6	0.8	0.4	0.0	0.7	0.3
Market Basket Update less Productivity Adjustment	2.0	2.0	2.4	2.2	2.0	3.6

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 principle that payments for physician services should vary in proportion to the resources required to provide those services. The RBRVS and Medicare Physician Fee Schedule are maintained by the American Medical Association (AMA) and CMS. RBRVS is maintained to serve the needs of the Medicare system and its population, and it is not typical for Medicare to reimburse services that are frequently utilized in Medicaid. Examples of Medicaid services that rely on RBRVS include surgical codes for maternity services and dental and non-physician-based behavioral health

[130] 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

[131] Centers for Medicare and Medicaid Services, "*CMS-1745-F and CMS-3347-F,"* (October 2022). Available online: https://www.federalregister.gov/documents/2022/08/03/2022-16457/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

[132] Centers for Medicare and Medicaid Services, *"Market Basket Data."* (December 2023). Available online: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html

procedures that are not a part of the Current Procedure Terminology (CPT) coding maintained by the AMA.

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.

The Medicare Physician Fee Schedule records two distinct Practice Expense (PE) RVUs for certain procedures. One is for services delivered in a facility, such as a hospital, and the other is for services delivered in a non-facility, which generally have a higher practice expense. The distinction is RVUs is intended to capture the significantly different economies of scale and overhead profiles of hospitals vs clinic and physician office settings.

Medicaid services such as anesthesia, maternity, and dental and non-physician-based behavioral health have notable reimbursement and rate setting methodologies that are described in detail below:

- Medicare reimburses anesthesiologists at the lower of the actual charge for a service or the anesthesia fee schedule amount. Medicare calculates the anesthesia fee schedule amount using an anesthesia-specific conversion factor (adjusted for regional differences) and “base” and “time” units (15-minute increments). The relative complexity of an anesthesia service is measured by base units.[133] These base units are added to the time units and multiplied by the conversion factor to produce the fee schedule amount.
- Medicare publishes a reimbursement rate and methodology for maternity service codes, but the rates do not necessarily align with the programmatic and financial needs of Medicaid programs, where the codes are more essential and frequently utilized.
- For dental and behavioral health services, the RBRVS either does not establish RVUs, or sets out only a limited set of values for specific services that might be performed by a physician.

[133] CMS generally determines its base units using those formulated by the American Society of Anesthesiologists in its 1988 *Relative Value Guide*.

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.[134] 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.[135] The minimum GPCI is also one for CYs 2021, 2022 and 2023.[136]

The CY 2022 PFS conversion factor decreased to $33.59 as a result of the budget neutrality adjustment and expiration of the three-point seven five percent (3.75%) temporary payment increase. [137]

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 two (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.[138,139] 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

[134] Centers for Medicare and Medicaid Services, "*Physician Fee Schedule"* (March 202). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched

[135] 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

[136] Centers for Medicare and Medicaid Services, "*Physician Fee Schedule"* (November 2022). Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched

[137] Centers for Medicare and Medicaid Services, "*CY 2022 Medicare Physician Fee Schedule Final Rule,"* (2021). Available online: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule

[138] Centers for Medicare and Medicaid Services, "*The Value Modifier (VM) Program."* Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram

[139] 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

Advanced Alternative Payment Models (APMs). The first performance period began on January 1, 2017.[140, 141, 142]

Congress delayed the two percent (2%) Medicare sequestration-based reimbursement reductions through March 31, 2022, and reduced sequestration reductions to one percent (1%) from April 1st through June 30, 2022.[143]

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.[144] 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.[145]

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. 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.[146]

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[140] 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

[141] 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.

[142] 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

[143] Protecting Medicare and American Farmers from Sequester Cuts Act, *"Rules Committee Print 117-22 Text of House Amendment to S. 610,'* (2021). Available online: https://www.congress.gov/bill/117th-congress/senate-bill/610/text

[144] Centers for Medicare and Medicaid Services, "*Medicare Claims Processing Manual Chapter 17 - Drugs and Biologicals," (*December 2022). Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf

[145] Centers for Medicare & Medicaid Services, "*Average Sales Price (ASP) Quarterly Publication Process Frequently Asked Questions,"* Available Online: https://www.cms.gov/files/document/frequently-asked-questions-faqs-asp-data-collection.pdf

[147] 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

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) directs CMS to update the statutory parameters for the defined standard Part D drug benefit each year. These parameters include the standard deductible, initial coverage limit, and catastrophic coverage threshold, and minimum copayments for costs above the annual out-of-pocket threshold. In addition, CMS is statutorily required to update the parameters for the low-income subsidy benefit and the cost threshold and cost limit for qualified retiree prescription drug plans eligible for the Retiree Drug Subsidy.[147,148]

In August 2022, the Inflation Reduction Act was signed into law. The Act contained key provisions designed to lower federal prescription drug spending. To aide in this goal, the Inflation Reduction Act included a policy that requires the Secretary of Health and Human Services (HHS) to negotiate prices with drug companies for specific high-cost drugs covered under Medicare Part D (starting in 2026) and Medicare Part B (starting in 2028). Additionally, the new guidance will require drug companies to pay a rebate to the federal government if prices for select Medicare Part B covered drugs (single source drugs and biologicals) and almost all Medicare Part D covered drugs increase faster than the rate of inflation (CPI-U).[149]

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.[150]

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*.[151]

Annually, the Indian Health Service (IHS) calculates and publishes new reimbursement rates in the Federal Register and are typically known as "All-Inclusive Rates (AIRs)". IHS establishes the

[147] 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

[148] 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.

[149] Centers for Medicare and Medicaid Services, "Inflation Reduction Act and Medicare," Available online: https://www.cms.gov/inflation-reduction-act-and-medicare

[150] Health Resources and Services Administration, "*Tribal and Urban Indian Health Centers,"* (June 2022). Available online: https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/tribal-urban-indian/index.html

[151] Indian Health Services, "*Medicare-Like Rates Information,"* Available online: https://www.ihs.gov/prc/medicare-like-rates-information/

AIRs based on the annual cost reports. Due to the higher cost of living in Alaska, separate rates are calculated for Alaska and the Lower 48 States.[152] The IHS hospital payment rates over the last few years are shown below.[153] [154] [155]

Lower 48 States

1. Medicare Inpatient Ancillary Part B
    a. CY 2021: $678
    b. CY 2022: $813
    c. CY 2023: $829
    d. CY 2024: $963
2. Medicare Outpatient
    a. CY 2021: $414
    b. CY 2022: $541
    c. CY 2023: $620
    d. CY 2024: $667

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 administration costs on a separate cost report worksheet, not on billed claims.[156] 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

[152] Indian Health Service, "*Reimbursement Rates,"* (December 2023). Available online: Reimbursement Rates | Division of Business Office Enhancement (ihs.gov)
[153] Centers for Medicare and Medicaid Services, "*CMS Manual System: Indian Health Services (IHS) Hospital Payment Rates for Calendar Year 2023,"* (December 2023). Available online: r11919cp.pdf (cms.gov)
[154] Federal Register, *"Reimbursement Rates for Calendar Year 2024*," (December 2023). Available online: Federal Register :: Reimbursement Rates for Calendar Year 2024
[155] Centers for Medicare and Medicaid Services, "*Pub 100-04 Medicare Claims Processing Transmittal 11397,"* (2022). Available online: https://www.cms.gov/files/document/r11397cp.pdf
[156] An RHC cannot 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.

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. 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. [157]

The RHC upper payment limit per visit applies to independent RHCs and RHCs that are provider-based to a hospital with fifty (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.[158] 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.[159,160] For CY 2020, the upper payment per visit is $86.31, representing a one-point nine percent (1.9%) increase from 2019.[161,162] Effective January 1, 2021, the upper payment limit per visit is $87.52, representing a one-point four percent (1.4%) increase from 2020. Beginning April 1, 2021 independent RHCs, provider-based RHCs in a hospital with 50 or more beds, and RHCs enrolled under Medicare on or after January, 2021 will receive a prescribed national statutory payment limit per visit increase over an 8-year period for each year from 2021 through 2028.[163] Beginning March 31, 2021, the CY 2021 national statutory payment limit per visit was increased to $100 as authorized under Section 1833(f)(2) of the Act. [164]

The rest of the national statutory payment limit for RHCs over the 8-year period are listed below:

- CY 2022: $113 per visit
- CY 2023: $126 per visit

[157] Centers for Medicare and Medicaid Services, *"Medicare Benefit Policy Manual, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services,"* (January 2021). Available online: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

[158] 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

[159] 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

[160] Calculated by multiplying the Calendar Year 2018 rate by the Medicare Economic Index and reflects a 1.5 percent increase.

[161] 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

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

[163] 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

[164] Medicare Learning Network, "*Update to Rural Health Clinic (RHC) Payment Limits*," (Revised May 2021), Available online: https://www.cms.gov/files/document/mm12185.pdf

- CY 2024: $139 per visit
- CY 2025: $152 per visit
- CY 2026: $165 per visit
- CY 2027: $178 per visit
- CY2028: $190 per visit

"Beginning 2029, and each proceeding year, the limit established for the previous year will be increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such year."[165]

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.

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.[166]

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.

[165] 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

[166] Medicare Learning Network, *"Rural Health Clinic"* (May 2023). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf

CMS revised the definition for "what constitutes a visit" in federal regulation § 405.2463. Effective CY 2022, RHCs will be paid at the same all-inclusive rate for telecommunication technology mental health visits as they are paid for in-person mental health visits. In order to be eligible for mental health telehealth visits, individuals must receive a mental health in-person service within 6 months prior to the telehealth service. In addition, an individual must receive an in-person mental health service at least every 12 months during the course of telehealth treatment. Limited exceptions are available based on the circumstances of the individual provided in a medical record by the practitioner.[167]

Vision

Original Medicare excludes routine vision care, such as routine eye exams. However, for individuals in certain high-risk groups, it does cover eye exams to check for specific conditions. 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.[168] 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.[169]

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[170]
- Family Planning Waiver - Pregnant by Choice Program

[167] Centers for Medicare and Medicaid Services, "*CMS-1751-F,"* (2021). Available online: https://public-inspection.federalregister.gov/2021-23972.pdf

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

[169] Centers for Medicare and Medicaid Services, *"Medicare Vision Services,"* (February 2023). Available online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/VisionServices_FactSheet_ICN907165.pdf

[170] 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.