Introduction

Medicare is the single largest purchaser of health care in the United States, accounting for 23 percent ($522 billion) of the $2.3 trillion spent on health care in 2011, according to the Medicare Payment Advisory Commission. In 2012, Medicare covered 50.7 million people: 42.1 million aged 65 and older, and 8.5 million disabled, according to the 2013 Medicare Trustees Report. In 2011, Medicare paid for 27 percent of all hospital care, 23 percent of physician services, 44 percent of home health services, 25 percent of nursing home care, 20 percent of durable medical equipment, and 24 percent of prescription drugs.

Medicaid provides coverage for 58 million people, and accounts for 16 percent of all health care spending. With the expansion of Medicaid eligibility provided under the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148), Medicaid spending will continue to grow.

According to the Congressional Budget Office, the share of gross domestic product (GDP) devoted to federal health care spending will almost double in the next 25 years, from 4.6 percent of GDP in 2013 to 8 percent of GDP in 2038.

With one-third of the U.S. population receiving health coverage through either Medicare or Medicaid, it will continue to be important for health care providers and practitioners, the legal and business advisors who support them, the legislators who pass laws amending the programs, and the administrators who regulate the programs, to stay on top of changes in the programs.

The Medicare and Medicaid Guide has been published since 1969. Available both in print and online, the Guide offers daily updates of new laws, regulations, court decisions, administrative decisions, and other guidance about these two health programs, in addition to over 500 explanations about how these programs work.

The complexity of the Medicare and Medicaid programs is often commented upon by judges when they write decisions based on the programs’ laws, regulations and other guidance. This overview highlights the complexity, but also provides a hint at the breadth of coverage in this product.

A full subscription to the Medicare and Medicaid Guide provides not only access to the full text of the explanations but also to a weekly newsletter and over 40 years of content – laws, regulations, cases, decisions, and other guidance.
Section I.—
Medicare Part A Coverage

Entitlement to Part A Benefits

Introduction to Medicare Part A Entitlement. There are several ways to become entitled to Medicare Part A hospital insurance benefits: (1) reaching the age of 65 and being eligible for monthly Social Security retirement or survivor benefits, railroad retirement, or Medicare-qualified government employment benefits; (2) reaching the age of 65 and paying Part A if not otherwise eligible; or (3) if under the age of 65, receiving Social Security disability or railroad disability benefits, or having end-stage renal disease. Persons must apply for Part A benefits.

Beginning Dates of Part A Entitlement. Medicare Part A benefits for automatically-entitled retirement beneficiaries begin with the first day of the first month in which the beneficiary has attained age 65. Those who become entitled due to disability, end-stage renal disease or premium enrollment have different beginning dates.

Social Security Retirement Beneficiaries. An individual who has applied for, and been determined to be entitled to, monthly Social Security retirement benefits is automatically entitled to Medicare Part A benefits beginning with the first day of the month he or she attains age 65. If the individual applies late, there is retroactive entitlement available for six months prior to the application date. There are entitlement restrictions for certain aliens outside of the USA and for those convicted of subversive activities.

Government Employee Beneficiaries. Medicare coverage was extended to federal government employees in 1983 and then to state and local government employees in 1986. Government employees were required to begin paying the hospital insurance (“Medicare”) portion of the Federal Insurance Compensation Act (FICA) tax at these times. Certain employment is not “Medicare-qualified.”

Railroad Retirement Beneficiaries. A qualified beneficiary under the Railroad Retirement Act of 1974 also is automatically entitled to Part A benefits on the same basis as a person entitled under Social Security (i.e., on the basis of having attained age 65 or being entitled on the basis of disability).

Disability Beneficiaries. Medicare disability benefits are provided to: disabled workers under age 65; disabled widows and widowers between the ages of 50 and 65; women age 50 or older entitled to mothers’ benefits; people age 18 and over who receive Social Security benefits because they became disabled before reaching age 22; and disabled qualified railroad retirement annuitants. There is a 24-month waiting period and Part A coverage begins with the 25th month of entitlement to Social Security disability benefits.

Voluntary Part A Enrollment for Uninsured Individuals. Part A coverage is available on a voluntary basis to individuals 65 or over who are not entitled to Social Security. There are two kinds of enrollment periods for these individuals, an initial period and an annual/general enrollment period.

End-Stage Renal Disease. Medicare Part A covers individuals who have not reached age 65 and who are suffering from end-stage renal disease (ESRD). They must either be entitled to monthly Social Security or railroad retirement benefits or be the spouse or dependent child of such an individual. There are specific beginning and ending dates of coverage. Facility, home and physician reimbursement are summarized.

Deductibles and Coinsurance

Beneficiary Cost Sharing: Deductibles and Coinsurance Under Part A. Under Medicare Part A, the hospital benefit, beneficiary contributions consist of both cash deductibles and coinsurance amounts. Part A also requires skilled nursing facility and hospice coinsurance, and blood deductibles.

Beneficiary Cost Sharing: Part A Premiums for Uninsured and Disabled Individuals. Certain persons aged 65 and older who are uninsured under the Social Security Old-Age, Survivors and Disability Insurance (OASDI) program or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Medicare Part A, and certain disabled individuals who have exhausted other entitlement, may voluntarily enroll in Medicare Part A, subject to payment of a monthly premium, which is not charged to those who are automatically insured under Part A.

Inpatient Hospital Services

Definition of “Inpatient.” An inpatient is a person who has been formally admitted to a hospital with the expectation of occupying a bed to stay overnight and receive inpatient hospital services.

Physician Certification and Recertification of Hospital Services. The law requires a physician to certify that the patient needed inpatient hospital services for medically necessary treatment or diagnostic study. A certification is not required until after inpatient hospital services have been furnished over a period of time. No physician certification is required for the initial admission to the hospital.
Covered Inpatient Hospital Services

Accommodations and Use of Facilities. Ordinarily, Medicare will pay for hospital bed and board only for semi-private (two to four beds) accommodations, but ward accommodations (five or more beds) are permitted when semi-private rooms are unavailable. Medicare will pay for private rooms when they are considered medically necessary or when the provider only has private rooms.

Drugs and Biologicals. Drugs and biologicals are covered by Part A only if they: (1) ordinarily furnished by the hospital for inpatients to use in the hospital; (2) represent a cost to the hospital; (3) are included in official drug compendia or are approved by the hospital’s pharmacy or drug therapeutics committee; and (4) are safe and effective and otherwise reasonable and necessary.

Supplies, Appliances, and Equipment. Supplies, appliances, and equipment are covered as inpatient hospital services under certain circumstances.

Other Diagnostic or Therapeutic Items or Services. To be covered under Medicare Part A, diagnostic or therapeutic items or services must be ordinarily furnished to inpatients either by the hospital or by others, under arrangements made by the hospital, and they must be billed by the hospital. Examples include therapist and independent clinical laboratory services.

Interns and Residents-in-Training. Medicare Part A, which does not cover physician services, does cover the services of interns or residents-in-training under a teaching program approved by the appropriate approving body.

Inpatient Services Connected with Dental Services. Dental services, which are not ordinarily covered under Part A, may be covered if the individual, because of an underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization for the performance of those services.

Emergency Inpatient Services in Nonparticipating Hospitals. Medicare Part A will pay for emergency services provided in a nonparticipating hospital if: (1) the services would otherwise be covered if provided in a participating hospital, (2) the hospital has a special payment agreement with CMS, and (3) the nonparticipating hospital is the most accessible hospital available to that is equipped to furnish the services needed.

There are specific definitions for emergency services and emergency service hospitals. There are special rules for coverage of services furnished in foreign hospitals.

Religious Nonmedical Health Centers. Medicare covers services furnished by religious nonmedical health care institutions (RNHClCs) if the institution meet 10 qualifying conditions. A Medicare beneficiary must have filed a statement with CMS electing this type of benefit and must have a condition that would qualify him or her for Medicare inpatient or skilled nursing facility benefits. Medicare payments to RNHClCs are limited by law, and if triggers are reached, then RNHClCs may increase their charges to their patients to make up for the reduction.

Inpatient Hospital “Ancillary” Services Under Part B. Certain inpatient hospital “ancillary” services can be covered under Part B when coverage is no longer provided under Part A. This can be an important benefit when Part A inpatient hospital or skilled nursing facility (SNF) days of coverage are used up, a patient is receiving only noncovered custodial care services, or coverage under Part A is not available but coverage under Part B is available.

Limitations on Inpatient Hospital Coverage

“Spell of Illness” Defined. A “spell of illness “is the number of days of coverage for Medicare inpatient hospital services and for skilled nursing facility (SNF) post-hospital services. A “spell of illness” begins on the first day a beneficiary is furnished inpatient hospital or SNF services by a qualified provider and ends when the beneficiary has neither an inpatient of a hospital nor an SNF for 60 consecutive days. A beneficiary may have more than one spell of illness per year.

A “spell of illness “is the number of days of coverage for Medicare inpatient hospital services and for skilled nursing facility post-hospital services.

Duration of Covered Inpatient Hospital Services. Part A entitles patients to up to 150 days of inpatient hospital services during a single spell of illness. The first 60 days are fully paid, subject to the initial deductible amount. The next 30 days are subject to a coinsurance amount and the last 60 days are subject to a coinsurance amount double the coinsurance amount for days 61 through 90. Days 91 through 150 are lifetime reserve days, which may be used only once. A beneficiary may elect not to have Medicare pay for lifetime reserve days, thereby saving them for later. Inpatient
service days, non-participating hospital emergency service days, and psychiatric hospital days all count towards the lifetime limitations.

Inpatient Psychiatric Hospital Services. There is a 190 day lifetime limit on Medicare Part A payment for inpatient psychiatric hospital services. There is also a 60-day “carry-over” restriction on Medicare Part A payment for inpatient mental health services for patients who become entitled to Part A benefits while they are inpatients of psychiatric hospitals.

Exclusion of Physicians’ Professional Services. The medical and surgical services of physicians are excluded from coverage under Part A of the Medicare program, and generally covered under Part B.

Skilled Nursing Facility Services

Introduction to Skilled Nursing Facility Services. Skilled nursing facility (SNF) services, which are similar to hospital inpatient services, provide inpatient care to patients needing a lower level of care and are covered under Part A.

Prior Hospitalization and Transfer Requirements. For Medicare Part A to pay for skilled nursing facility (SNF) services, a patient first must have been an inpatient of a hospital for at least three consecutive calendar days and have been transferred to the SNF, usually within 30 days after discharge from the hospital. The three-day prior hospitalization and thirty-day transfer rules are explained below.

Skilled Nursing Facility Services. Physicians must certify and recertify the need for skilled nursing services at a skilled nursing facility (SNF) or in an approved swing-bed in a hospital. The original certification is to occur within 5 working days of admission to the SNF or swing-bed. The first recertification is to occur within 14 days of admission and subsequent recertifications occur every 30 days thereafter.

Covered SNF Services

SNF Accommodations. The coverage of ward, semiprivate, private, and deluxe accommodations in a skilled nursing facility (SNF) is treated the same as coverage of these types of accommodations in a hospital. There are special rules for SNF patients in inappropriate beds. Thus, in general, the provisions relating to accommodations in hospitals also are applicable to skilled nursing facilities.

Supervised Nursing Care; Private-Duty Exclusion. Nursing care provided by a skilled nursing facility is covered under Part A if it is furnished by, or under the supervision of, a registered professional nurse. The services of a private-duty nurse or other private-duty attendant, however, are excluded.

Physical and Occupational Therapy and Speech-Language Pathology Services. Physical, speech, and occupational therapy furnished by a skilled nursing facility (SNF) (or by others under arrangements made by the facility) are covered by Medicare Part A if provided under a physician’s orders and furnished by or under the supervision of a qualified therapist.

Medical Social Services. Medical social services including the assessment of social, medical, and nursing requirements, as well as case work services, are provided to skilled nursing facility residents under Medicare Part A.

Drugs and Biologicals. Drugs and biologicals used in skilled nursing facilities (SNFs) are covered by Medicare Part A, including those routinely stocked and those obtained for the patient from an outside source, such as a retail pharmacy. Drugs and biologicals are included in the SNF prospective payment system except for those Part B drugs specifically excluded. SNFs must assure the availability of drugs to inpatients, as it is a condition of participation in Medicare.

Supplies, Appliances, and Equipment. Supplies, appliances, and equipment are covered by Medicare Part A as extended care services in skilled nursing facilities (SNFs) only if they are ordinarily furnished by the SNF for the care and treatment of inpatients, and if furnished to the patient for use in the SNF or necessary for the patient’s departure. Examples include blood, oxygen, surgical dressings, splints, casts, and personal hygiene items and services.

Other Diagnostic and Therapeutic Items or Services. Medicare Part A covers services that are necessary to a patient’s health if the services are generally provided by, or under arrangements made by, skilled nursing facilities.

Interns and Residents-in-Training. The medical services of an intern or resident-in-training under an approved teaching program of a hospital with which the skilled nursing facility has the required transfer agreement are covered under Part A, although physician services are not covered.

Inpatient SNF “Ancillary” Services Covered Under Part B. The medical and health services listed in this section are covered under Medicare Part B when furnished by a skilled nursing facility (SNF) either directly or under arrangements to SNF patients who are no longer entitled to have payment made under Part A.

Religious Nonmedical Health Care Institutions. Medicare Part A covers skilled nursing facilities services furnished in a Medicare qualified religious nonmedical health care institution (RNHCI) when a beneficiary meets the Social Security Act’s specific coverage conditions.
**Limitations on SNF Coverage**

“Spell of Illness” Defined. The rules defining a “spell of illness” apply to both inpatient hospital services and skilled nursing facility services.

Duration of Covered SNF Services. A patient covered under Medicare Part A is entitled to have payment made on his or her behalf for up to 100 days of covered inpatient skilled nursing facility (SNF) services in each spell of illness, subject to the coinsurance requirement. There are special rules for counting days and leaves of absence.

**Home Health Services**

Home Health Services. The Medicare program, under both Part A and Part B, covers home health services furnished by a home health agency (HHA) under a plan established and reviewed by a physician.

Billing and Coding. A home health prospective payment system (HH PPS) was established in 1997. The unit of payment for the HH PPS is a 60-day episode, covering all services and supplies furnished by a home health agency (HHA) except for durable medical equipment, osteoporosis drugs, and items such as vaccines that are not part of the HH benefit. All items and services must be billed by the HHA in a consolidated bill to the regional home health intermediary. There are special rules for when services and supplies are paid under Medicare Part A or Part B.

Conditions of Coverage for Home Health Services

Reasonable and Necessary Rule. A physician must certify the need for Medicare-covered home health services and establish a plan of care for the patient, which must be submitted to CMS. The Secretary is responsible for ensuring that the claimed services are covered by Medicare, including determining whether they are “reasonable and necessary.”

Advance Beneficiary Notices. Whenever a home health agency (HHA) believes that home health services ordered by a physician will not be covered by Medicare, the HHA must inform the patient, orally and with a written “advance beneficiary notice” (ABN) detailing the expected federal (Medicare, Medicaid, and other) payment, the charges that will not be covered by Medicare, and the charges that the patient will need to pay. ABNs must be sent to beneficiaries after certain listed triggering events.

Physician Certification and Recertification of Home Health Services. No payment can be made for covered home health services unless the physician who established the plan certifies to the necessity for home health services and, when services are to continue for a period of time, recertifies as to the continued need for services.

Services Furnished by an Agency or by Others “Under Arrangements”. Home health items and services must be furnished by a home health agency (HHA) or by others under arrangements made by the HHA. The HHA must exercise professional responsibility over the arranged-for services through a written contract, record-keeping, and communication with the attending physician.

Services Furnished Under a Plan. Items and services covered by Medicare for home health patients must be furnished under a plan established and periodically reviewed by a physician.

Patient Confined to Home. A physician must certify that a patient receiving Medicare home health benefits is confined to his or her home. A patient need not be bedridden but must have an inability to leave home without effort and the use of supportive devices such as crutches, cranes, wheelchairs, walkers, or the assistance of another person. A patient may make occasional trips outside the home.

Covered Home Health Services

Skilled Nursing Care. Medicare covers skilled nursing services for home health beneficiaries when the services: (1) are ordered by the treating physician and included in the plan of treatment; (2) are required on a part-time or intermittent basis; (3) require the skills of a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse; and (4) are reasonable and necessary to the treatment of an illness or injury.

Physical and Occupational Therapy and Speech-Language Pathology Services. Physical and occupational therapy and speech-language pathology services furnished by a home health agency (HHA) or by others under arrangements made by the HHA are covered by Medicare when provided under a physician’s orders and by, or under the supervision of, a qualified therapist. Initial occupational therapy services must be part of a plan of care that also includes intermittent skilled nursing care, physical therapy, or speech-language pathology services.

Medical Social Services. Medical social services are covered by Medicare as home health services if ordered by a physician and included in the plan of care. The frequency and nature of the services must be reasonable and necessary. They are covered only if the beneficiary needs skilled nursing care on an intermittent basis, physical therapy or speech-language pathology services,
or occupational therapy services on a continuing basis. Services must be necessary to resolve social or emotional problems that are, or are expected to become, an impediment to the effective treatment of the patient's medical condition or rate of recovery, and the plan of care indicates how a qualified social worker or social worker assistant under the supervision of a qualified medical social worker may safely and effectively perform the services.

**Home Health Aide Services.** Medicare covers the part-time or intermittent reasonable and necessary services of a home health aide for the personal care of a qualifying patient when ordered by a physician. Home health aides must be trained and certified.

**Medical Supplies and Durable Medical Equipment.** Medical supplies have therapeutic or diagnostic characteristics that make them essential to enable home health agency personnel to effectively carry out care ordered by the physician for the treatment or diagnosis of a home health patient's illness or injury. Supplies must be needed to treat the patient's illness or injury that occasioned the home health care. Medical supplies are either routine, used in most home visits, or non-routine, specifically ordered by the physician for a particular patient.

**Services of Interns and Residents.** Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program if ordered by the physician responsible for the plan of care and if the home health agency is affiliated with or is under common control of a hospital furnishing the medical services.

**Outpatient Services.** Outpatient items and services are covered under Medicare's home health benefit if they are provided under arrangements on an outpatient basis at a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school, and if they: (1) require equipment that cannot readily be made available at the patient's place of residence, or (2) are furnished while the patient is at the facility to receive covered services requiring this equipment. The outpatient facilities above must be qualified providers of services, and there are special provisions, for the use of the facilities of rehabilitation centers. The cost of transporting an individual to a facility is not reimbursed as a home health service.

**Limitations on Home Health Coverage**

**Exclusions from Coverage.** Items and services excluded under Medicare's home health benefit include (1) drugs and biologicals, except for osteoporosis drugs; (2) transportation of beneficiaries, whether to receive covered care or for other purposes; (3) services or items that would not be covered if provided to an inpatient of a hospital; (4) housekeeping services; (5) end-stage renal disease (ESRD) services that are covered under the special ESRD composite payment rate; (6) prosthetic devices; (7) medical social services provided to families; (8) venipuncture for the purposes of obtaining a blood sample; (9) respiratory care services; and (10) dietary and nutrition personnel.

**Visits.** Each visit with a home health beneficiary by staff of the home health agency (HHA), or by others through arrangements with the HHA, for the purpose of providing a covered service, must be uniquely billed as a separate line item on a Medicare HHA claim.

**Hospice Services**

**Introduction.** Medicare provides hospice care for the terminally ill. It includes supportive services such as home care and pain control, rather than the cure-oriented services. A Medicare beneficiary who is terminally ill may elect to receive hospice care for two periods of 90 days, and an unlimited number of periods of 60 days each. When a beneficiary chooses a hospice program, he/she gives up the right to receive most other Medicare benefits, but this election is revocable. There is a small coinsurance applicable to drugs and biologicals, and the beneficiary must pay 5 percent of the reasonable cost of any respite care.

**Hospice Election.** A beneficiary entitled to Medicare Part A benefits may make a written, signed election to receive hospice benefits if his/her life expectancy is six months or less and both the beneficiary's attending physician and the medical director/staff physician of the hospice program certify that the illness is terminal. The election may be revoked. Changing from one hospice provider to another is not considered a revocation of election. Effective January 1, 2011, there is a new requirement for a face-to-face encounter between a patient and a hospice physician/nurse practitioner before a recertification may be made.

**Physician Certification and Recertification of Hospice Services.** Medicare covers hospice care when the beneficiary is certified to be terminally ill by the hospice's medical director or the physician member of the hospice interdisciplinary group as well as the beneficiary's attending physician. Since January 1, 2011, a hospice physician or nurse practitioner (NP) must have a face-to-face encounter with each hospice patient whose total stay is anticipated to reach the 3rd benefit period. The face-to-face encounter must
for Medicare-eligible individuals who continue working and are covered by their employer’s group health plan.

**Automatic Enrollment.** Residents of the United States entitled to Medicare Part A are automatically enrolled in Part B unless they elect to decline coverage.

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The Medicare Part B program, also called supplementary medical insurance (SMI), is a voluntary program open to all individuals who are entitled to Part A hospital insurance.

Those who do not decline coverage before it is scheduled to begin are deemed to have automatically enrolled.

**Coverage Period.** The coverage period of an individual who has enrolled in the Part B program is the period during which he or she is entitled to Part B benefits and the period for which premiums are due. To obtain the earliest possible coverage, an individual should enroll during the three months of the initial enrollment period that are before the month in which the individual reaches age 65.

**Termination of Coverage.** An individual’s coverage period continues until his or her enrollment is terminated. Termination occurs on the beneficiary’s death, if the individual files a notice that he or she no longer wishes to participate in the program, or if the individual fails to pay the required premiums.

**Benefits Under the Part B Program**

**Overview of Part B Benefits.** The Medicare Part B benefit supplements the benefits provided by the Part A program. Specifically covered under the Part B provisions of the law are: “medical and other health services;” home health services; comprehensive outpatient rehabilitation facility services; and ambulatory surgical center (ASC) services.

**Physician Services.** The Part B program covers services by the physician furnished directly to the patient, and certain professional services, except services performed by certain interns, residents, or teaching physicians and covered under Part A.

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**Section II.— Medicare Part B Coverage**

**Eligibility, Enrollment and Coverage Period**

**Eligibility for Part B Benefits.** The Medicare Part B program, also called supplementary medical insurance (SMI), is a voluntary program open to all individuals who are entitled to Part A hospital insurance. An individual may enroll in Part B without being eligible for Part A if the individual meets the Part B eligibility criteria.

**Enrollment in the Part B Program.** Anyone entitled to Part A benefits, including one entitled by reason of disability or end-stage renal disease, is enrolled and covered for Part B benefits automatically, unless the individual indicates that he or she does not want to be enrolled in the Part B program.

**Enrollment Periods.** An individual may enroll in the Part B program only during: (1) an initial enrollment period, based on the date when an individual first meets the eligibility requirements for enrollment; (2) a general enrollment period for individuals who failed to enroll during an initial enrollment period or whose enrollment has been terminated; and (3) a special enrollment period
Services and Supplies Incident to Physicians’ Services. Part B covers services and supplies—including drugs and biologicals that are not usually self-administered—furnished incident to the services of a physician (or other practitioner) in a noninstitutional setting to noninstitutional patients.

Ambulatory Surgical Services. Medicare Part B covers surgical procedures that ordinarily are performed on an inpatient basis but, consistent with sound medical practice, can be performed on an outpatient basis. CMS has developed and frequently updates a list of surgical procedures that can appropriately and safely be performed on an outpatient basis in an ambulatory surgical center (ASC) or in a hospital outpatient department instead of in a hospital on an inpatient basis.

Rural Health Clinic and Federally Qualified Health Center Services. Services provided by rural health clinics (RHCs) and federally qualified health centers (FQHCs) are covered by Part B, including the services of physicians and other health care professionals.

Home Health Services Under Part B. Part B covers home health visits in excess of 100 used by a beneficiary during a “post-institutional spell of illness” that began with a hospital or skilled nursing facility stay; Part A pays for the first 100 visits. If a beneficiary uses any home health visits during a period that is not a “post-institutional spell of illness,” all the visits will be paid for under Part B.

Outpatient Hospital Services. Hospitals provide two distinct types of services to outpatients covered under Part B: (1) therapeutic services, services that aid the physician in the treatment of his or her patient, and (2) diagnostic services, such as x-rays or laboratory services.

Mental Health Services and Partial Hospitalization. Because of the wide range of services and programs hospitals provide for outpatients who need mental health or psychiatric care, Part B payment is made only for services that meet the requirements of the outpatient hospital Medicare benefit. The mental health or psychiatric services must be: (1) incident to a physician’s service, that is, prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members, and (2) reasonable and necessary for the diagnosis or treatment of the patient’s condition. In addition, the services must reasonably be expected to improve the patient’s condition.

Drugs and Biologicals. Drugs and biologicals are covered only if: (a) they meet the definition of drugs or biologicals; (b) they are of the type that are not usually self-administered by the patient; (c) they meet all the general requirements for coverage of items as “incident to” a physician’s services; (d) they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice; (e) they are not excluded as immunizations; and (f) they have not been determined by the Food and Drug Administration (FDA) to be “less-than-effective.”

Physical and Occupational Therapy and Speech-Language Pathology Services. The Part B program covers outpatient physical and occupational therapy and speech-language pathology services when the following conditions of coverage are met. The services must be: (1) by (or under arrangements with) a participating provider of services, clinic, rehabilitation agency, or public health agency; (2) by or under the direct supervision of a qualified therapist in independent practice; or (3) by or incident to the services of a qualified physician or practitioner who is licensed to perform such services under state law.

Rehabilitation Facility Services. Part B covers items and services furnished by a comprehensive outpatient rehabilitation facility (CORF), which is a provider that is capable of providing a broad array of rehabilitation services on an outpatient basis at a central location.

Diagnostic X-Ray, Laboratory, and Other Diagnostic Tests. Coverage is provided for diagnostic x-ray services when the services are furnished by a physician or as incident to a physician’s services. Diagnostic x-ray services furnished by a portable x-ray supplier are covered when performed under the general supervision of a physician. Diagnostic laboratory tests are covered when furnished by a qualified hospital, clinical laboratory, clinic, or physician’s office laboratory. There are special rules for psychological tests, otologic evaluations, and electrocardiograms.


Surgical Dressings, and Devices for Reduction of Fractures. Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations are covered under Part B but are not separately payable in certain situations.

Durable Medical Equipment. Durable medical equipment (DME) that is furnished to a beneficiary for use in the home is covered under the Part B program, whether furnished on a rental basis or purchased. The equipment must meet the definition of durable medical equipment and must be necessary and reasonable for the treatment of an illness or injury or to improve the functioning of a malformed body member.

Ambulance Service. Medically necessary ambulance services are covered under Part B when not covered...
by Part A payments to providers such as hospitals and nursing facilities.

**Prosthetic Devices.** Prosthetic devices, orthotics, and prosthetics (other than dentures) are covered under Part B and included in the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive acquisition program.

**Braces, Trusses, and Artificial Limbs and Eyes.** Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes are covered when furnished incident to a physician’s services or on a physician’s order. Replacements of artificial limbs and parts of artificial limbs are covered when there is a change in the condition of the patient or a change in the condition of the device.

**Inpatient Ancillary Services.** Some items and services that constitute “medical and other health services” covered under Part B may be covered under Part A when furnished to inpatients. No payment may be made under Part B with respect to any services furnished an individual to the extent that the individual is entitled to Part A payment for the services. When a hospital inpatient has exhausted his or her 90 days of entitlement in a “spell of illness” or is otherwise not entitled to Part A payment, “medical and other health services” are covered and paid under Part B, even though they are furnished to an inpatient of a hospital or skilled nursing facility.

**Certified Registered Nurse Anesthetist (CRNA) Services.** The services of a certified registered nurse anesthetist (CRNA), including anesthesia services and related care, are covered by Medicare Part B, effective January 1, 1989. Services covered include anesthesia services and related care.

**Nurse-Midwife Services.** The services of certified nurse-midwives are covered by Medicare, beginning July 1, 1988. A “certified nurse-midwife” is a registered nurse who successfully has completed an approved program of study and clinical experience in nurse-midwifery or who has been certified by an organization recognized by the Secretary. Services covered include services furnished by a certified nurse-midwife (as well as services and supplies furnished incident to a nurse-midwife’s services) to the same extent the services would be covered if furnished by a physician.

**Qualified Psychologist and Clinical Social Worker Services.** The services of a qualified psychologist are covered by Medicare. A “qualified psychologist” is a clinical psychologist (CP) who provides the kind of services that would be covered if furnished by a physician or as incident to a physician’s services. The services of CPs are not covered if they are otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by state law to perform them.

**Preventive Screening Services and Tests.** Medicare Part B covers specific preventive screening services and tests. The Initial Preventive Physical Exam (IPPE), performed within the first year of Part B enrollment, begins the process. Effective in 2011, Medicare beneficiaries are eligible to receive personalized prevention plan services every year after their IPPEs as long as they have not received either an IPPE or personalized prevention plan services within the preceding 12-month period.

**Therapeutic Shoes for Diabetics.** Therapeutic shoes have been covered by Medicare since May 1, 1993, for beneficiaries with severe diabetic foot disease. Coverage is limited to one of the following within a calendar year: (1) one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or (2) one pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of inserts.

**Beneficiary Cost Sharing**

**Beneficiary Cost Sharing: Deductibles and Coinsurance Under Part B.** In addition to the monthly premium charged to those enrolled in Medicare Part B, beneficiaries also must pay deductible and coinsurance (copayment) amounts. After application of the annual deductible, the Medicare payment amount is 80 percent of the Medicare-allowed charge, and thus, the beneficiary is responsible for the remaining 20 percent copayment. There are exceptions when deductibles and copayments are not applied, as well as special payment rules for blood and outpatient mental health services.

**Beneficiary Cost Sharing: Part B Premiums.** The standard Medicare Part B premium is set by actuaries to cover 25 percent of the costs of the Part B program, but at times premium rates have been set by statute rather than by the actuarial formula. The federal government is required by statute to supplement the remainder of Part B costs out of general revenues. Premium amounts, premium collection, late enrollment penalties, and grace periods are discussed in this section.

**Section III.—Part B Payments—General**

**General Limits and Payment Rules**

**Introduction to Part B Payments.** Medical services and supplies provided to beneficiaries by physicians, other health care practitioners, and suppliers are covered and paid for under the Part B portion of the Medicare program. Unlike Part A payments, which are based on
a prospective payment or reasonable cost basis, Part B payments generally are based on fee schedules that have replaced the reasonable charge payment method used before the adoption of the physician fee schedule in 1992. Reasonable cost or charge methods, however, are used to pay for rural health clinic and federally qualified health clinic services; drugs or biologicals supplied by physicians to their patients; and medical supplies or devices not covered by fee schedules.

Limiting Charge. The “limiting charge” restricts how much physicians or other healthcare practitioners and suppliers are allowed to charge a Medicare patient if they do not accept assignment. The limiting charge is 115 percent of the fee schedule amount for “nonparticipating physicians,” which is, in turn, 95 percent of the fee schedule amount for each service.

Other Actual Charge Restrictions. A number of limitations on actual charges became obsolete with the adoption of the physician fee schedule and a “limiting charge” in 1992.

Reasonable Charge Payment Method

Reasonable Charge Method. Prior to the implementation of the Physician Fee Schedule, Medicare paid for most items and services covered under the Part B program on a “reasonable charge” basis. The reasonable charge methodology generally is no longer used to calculate Part B payments, although related payment limitations such as inherent reasonableness and inflation-indexed charges apply to some items not paid under fee schedules.

The Customary Charge. Under the reasonable charge payment method used when no Part B fee schedules apply, the “customary charge” is the amount that a physician or supplier usually charged for a specific item or service. The “reasonable charge” may not be higher than the individual physician’s or supplier’s customary charge.

The Prevailing Charge. The term “prevailing charges” refers to those charges that fall within the range of charges most frequently and most widely used in a locality for particular medical procedures or services. The top of this range establishes an over-all limitation on the charges that the Medicare administrative contractor (MAC) will accept as reasonable for a given service, except where unusual circumstances or medical complications warrant an additional charge.

Lowest Charge Level and Comparable Circumstances. Under a payment limit that is no longer used, in the case of medical services, supplies, and equipment that do not generally vary significantly in quality from one supplier to another, the charges determined to be reasonable may not exceed the lowest charge level (LCL) at which such services, supplies, and equipment are widely available in a locality.

Inflation-Indexed Charge. An additional factor—the inflation indexed charge (IIC)—is added to the factors taken into consideration in determining reasonable charges for nonphysician services. “Nonphysician services” for this purpose are Part B medical services, supplies, and equipment reimbursed on a reasonable charge basis and not covered under or limited by the fee schedule for physicians’ services.

Inherent Reasonableness. Prior to the implementation of the Medicare physician fee schedule on January 1, 1992, the Secretary was authorized to make payment reductions for physician services found not to be “inherently reasonable.” The use of inherent reasonableness was restored, effective August 5, 1997, for nonphysician services and supplies. It extended the authority of Medicare carriers (now called Medicare administrative contractors (MACs)) to establish special payment limits regardless of the methodology used for determining payment and simplified the inherent reasonableness process for adjustments to payment amounts.

Other Payment Rules

Clinical Diagnostic Laboratory Tests. Medicare Part B pays for clinical laboratory tests performed in a physician’s office, by an independent laboratory, or by a hospital laboratory for its outpatients on the basis of area-wide fee schedules. Current exceptions to this rule are critical access hospital (CAH) laboratory services and services provided by hospitals in the state of Maryland.

Productivity Adjustment for Miscellaneous Items and Services. A “productivity adjustment” was incorporated into all Medicare payment formulas, from payments for hospital and other provider services to Part B items and supplies, effective beginning in 2011.

Assignment. In the case of Part B payment for physician services and certain additional “medical and other health services,” payment may be made either to the beneficiary or directly to the physician or supplier pursuant to an assignment agreement.

Participation Program for Physicians and Suppliers. Physicians and suppliers are encouraged to sign a “participation” agreement with Medicare binding them to accept assignment for all services provided to all Medicare patients for the following year. Those who choose not to sign a participation agreement (they are termed “nonparticipating” physicians and suppliers) may accept assignment on a case-by-case basis.

“Pay for Performance” Initiatives. Through collaborative efforts with other public agencies and private organizations with a common goal of improving quality
and avoiding unnecessary health care costs, CMS has developed and implemented a set of pay-for-performance initiatives to support quality improvement in the care of Medicare beneficiaries.

**Rural Health Centers and Federally Qualified Health Centers.** Although a Medicare prospective payment system is under development for federally qualified health centers (FQHCs) for cost reporting periods beginning after October 1, 2014, until that time rural health clinics (RHCs) and FQHCs that are provider-based are paid under Medicare’s “reasonable cost” rules; those that are independent clinics are paid on the basis of an “all-inclusive rate” for each beneficiary visit for covered services, except for pneumococcal and influenza vaccines and their administration, which are paid at 100 percent of reasonable cost.

### Section IV.—Part B Payments—Physician Fee Schedule

**Physician Fee Schedule**

**Introduction to the Physician Fee Schedule.** Effective January 1, 1992, a national fee schedule was established to pay for the services of physicians and nonphysician practitioners to Medicare beneficiaries based on the “relative value” of services instead of customary and prevailing charges. In addition, certain limited license practitioners, such as chiropractors and optometrists, are treated as “physicians” for payment of some of their services.

**Commission Recommendations.** The Medicare Payment Advisory Commission (MedPAC) is charged by Congress with reviewing all Medicare payment policies, including the Medicare Advantage program, and making recommendations to Congress on Medicare-related issues. Another advisory group, the Practicing Physicians Advisory Council, was discontinued in 2010.

**Transition Rules.** The physician fee schedule became effective on January 1, 1992. To ease the transition from the reasonable charge system to the fee schedule, a four-year phase-in period was provided for some services so that the prior payment level was replaced gradually. Beginning in 1996, the fee schedule became fully implemented.

**Incentive Payments.** The Medicare payment is increased to provide certain incentives for physicians. Examples are the bonus payments in Health Professional Shortage Areas or for some mental health services. The Medicare program also uses payment incentives to promote the use of electronic health records and the reporting of quality data. Payment incentives also promote enrollment of physicians, other healthcare practitioners, and suppliers.

**Payment Formula.** To calculate the Medicare fee schedule “payment amount” for every physician’s service, the components of the fee schedule (physician work, practice expense (PE), and malpractice relative value units (RVUs)) are adjusted by a geographic practice cost index (GPCI). The GPICS reflect the relative costs of physician work, PE, and malpractice insurance in an area compared to the national average costs for each component. RVUs are converted to dollar amounts through the application of a conversion factor (CF), which is calculated by CMS’s Office of the Actuary.

Currently, payment for services is calculated as follows:

\[
\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU practice expense} \times \text{GPCI practice expense}) + (\text{RVU malpractice} \times \text{GPCI malpractice})] \times \text{conversion factor}.
\]

**Relative Values.** Almost every medical procedure recognized by Medicare has been assigned units of value for the various resources used in providing the service relative to all other services. For the most part, the Medicare program’s list of medical services and procedures is taken from the American Medical Association’s Common Procedural Terminology, Fourth Edition (CPT®-4), and it uses the same code numbers for description and billing (along with supplementary codes developed by HHS for items and services not included in the AMA publication).

The supplementary codes, sometimes referred to as “alphanumeric” codes, are distinguishable from CPT® codes because they begin with a letter rather than a number. The complete list of Medicare procedure codes, including the both the CPT® codes and the alphanumeric codes, is called the Healthcare Common Procedure Coding System (HCPCS).

**Geographic Adjustment Factor.** Geographic adjustment factors (GAFs) are used to modify the relative value of each procedure. CMS creates a separate GAF for each of the three components of the relative value unit for each procedure to adjust each of those components individually. These factors are often described as “geographic practice cost indices” (GPICS).

**Conversion Factor.** A national conversion factor translates the relative value units (RVUs) for physician fee schedule services into a payment amount. For anesthesia services, a separate table of conversion factors for 90 geographic areas is used to calculate payments based on type of surgery or procedure and time units.

**Sustainable Growth Rate (SGR).** Beginning in 1999, the Sustainable Growth Rate (SGR) replaced
the former Volume Performance Standard (VPS) as the target-setting factor in the Medicare physician fee schedule (PFS) conversion factor update formula. The SGR is linked to changes in the U.S. gross domestic product (GDP), while the VPS was linked to the growth in medical inflation.

The SGR was expected to result in lower Medicare expenditures for physician services, and it has, in fact, produced a “negative update” to the conversion factor in recent years, which has continually been counteracted by legislation in Congress to maintain fee schedule rates.

Payment for Services and Supplies “Incident to” a Physician’s Services. Most of a physician’s office medical supplies are considered to be part of the physician’s practice expense and are included in the schedule payment. Services provided by the physician’s staff incident to the physician’s services are paid under the schedule as if the physician had personally furnished the services. Services of health care practitioners such as nurse practitioners and physician assistants may be billed and paid separately, in which case no payment is made to the physician.

Drugs. Beginning January 1, 2005, the payment limit for Part B drugs (including biologicals) is based on the average sales price (ASP) for the date of service plus 6 percent. Payment allowances for drugs are based on the lower of the submitted charge or the ASP file price. A competitive acquisition program (CAP) for physicians who administer drugs in their offices became available in 2006 but was discontinued at the end of 2008.

Special Payment Issues

Visits and Consultations. Medicare pays for visits and consultations based upon the American Medical Association’s (AMA) Current Procedural Terminology (CPT®) Evaluation and Management (E&M) codes. Similar E&M codes are distinguished by the level of complexity and difficulty of the service provided. Because of these distinctions, documenting the medical record becomes very important and led to the issuance of two sets of E&M guidelines from CMS in 1995 and 1997. In a reference tool published in December 2010, CMS clarified that either version of the documentation guidelines, not a combination of the two, may be used by the provider for a patient encounter.

Assistants at Surgery. The law permits payment under Part B for a physician assistant at surgery in a teaching hospital under certain conditions. In a teaching hospital setting, Medicare does not pay for assistant-at-surgery services when a resident physician at the hospital could have assisted but did not.

Surgery Rules and Modifier Codes. Payments for surgery are affected by billing rules that include global charge modifiers that indicate a charge for all the procedures and supplies involved in typical surgery, as well as other modifiers to describe complicated surgery or surgery involving co-surgeons.

Site-of-Service Differential. A physician’s practice costs are less when a service is performed in a health care facility instead of in the physician’s office. Accordingly, Medicare applies a special reduction in payment, called the “site-of-service differential,” when a service that is normally performed in a physician’s office (at least 50 percent of the time) is in fact performed in a facility.

Coding and Billing Requirements. Under the physician fee schedule, physicians, health care practitioners, and suppliers are required to use the CMS Healthcare Common Procedure Coding System (HCPCS) in billing Medicare for any service or procedure they provide. HCPCS includes the American Medical Association’s (AMA) Current Procedural Terminology (CPT®) procedure codes as well as additional codes, developed by CMS, that describe items or services not described by the AMA codes.

In addition, Medicare requires physicians, health care practitioners, and suppliers to use the International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM) diagnostic codes for each item or service billed under Part B.

Private Physician Contracts. Medicare beneficiaries and physicians and other health care practitioners may enter into private contracts for health care services outside the Medicare system. A physician or practitioner who enters into at least one private contract with a Medicare beneficiary to furnish health care services opts out of Medicare for a two-year period unless the opt-out is terminated. The physician’s or practitioner’s opt-out may be renewed for subsequent two-year periods. Services furnished under such private contracts are not covered services under Medicare, and no Medicare payment will be made for such services either directly or indirectly, except in limited cases.

Physician Quality Reporting System. The Physician Quality Reporting System (previously called the Physician Quality Reporting Initiative) is a voluntary program that provides a financial incentive to eligible professionals (EPs) and group practices who satisfactorily report on quality measures for covered professional services furnished to Medicare beneficiaries during a specified reporting period.
Facility-Based Physicians

Facility-based Physician Services. Medicare payments for services provided by physicians who are hospital-based or otherwise facility-based are divided into the “provider component” (paid to the facility) and the “professional component” (paid to the physician).

Radiologists. Payment for the services of radiologists is generally based on the professional component for a given service in the fee schedule, rather than a global payment that covers technical components. Facility services needed to produce the x-ray films or other items that are interpreted by the radiologist constitute the technical component of the service, for which payment usually is made directly to the facility.

Anesthesiologists. Anesthesiologists and certified registered nurse anesthetists are paid under the physician fee schedule (PFS) according to a formula using base units, time units, and a national conversion factor (adjusted by geographic area).

Pathologists. The physician fee schedule classifies only a small portion of the American Medical Association’s (AMA) Current Procedural Terminology (CPT®) manual’s pathology section (the 80000 series) as physician pathology services. The remainder are considered clinical laboratory services and are excluded from the physician fee schedule.

Physicians in Teaching Hospitals. Because Medicare pays only for care provided to individual patients, special rules have been devised for physicians in teaching hospitals, who have responsibilities to the hospital and its students, as well as to care for individual patients. These special rules apply to three kinds of physicians in teaching hospitals: (1) teaching and supervising physicians, (2) assistants at surgery, and (3) residents-in-training.

Renal Dialysis and Transplant Specialists. Physicians are paid for attending physician renal dialysis services, whether provided in a renal dialysis facility or in the patient’s home, based on a “monthly capitation payment” (MCP). Services not included in the MCP are paid under the physician fee schedule.

Other Health Care Practitioners

Physician Assistants, Nurse Practitioners, and Nurse Midwives. Separate Medicare payment is made for physician assistants and nurse practitioners. These practitioners are permitted to bill and be paid in their own right when they perform specialized services or take the place of a physician. The Medicare payment amount is a certain percentage of the fee schedule amount that would have been paid to a physician for the same services, and the nonphysician practitioner must accept Medicare assignment.

Certified Registered Nurse Anesthetists (CRNAs). Certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs) may bill Medicare directly for their services or have payment made to an employer or an entity under which they have a contract. This could be a hospital, physician, or ambulatory surgical center (ASC). For items and services furnished on or after January 1, 2010, teaching CRNAs are reimbursed 100 percent of the fee schedule amount if they are administering the item or service alone while training a physician resident.

Clinical Psychologists and Social Workers. Clinical psychologists certified by Medicare may be paid separately for their services; the services of other psychologists are covered only as incident to a physician’s services or as diagnostic tests. For therapeutic and other diagnostic services, clinical social workers are paid 75 percent of the physician fee schedule amount allowed for clinical psychologists.

Physical Therapists, Occupational Therapists, and Speech-Language Pathologists. Therapists in independent practice are not required to bill on an assignment basis and are not subject to the limiting charge. Beginning July 1, 2009, speech-language pathologists also may bill Medicare directly for their services.

Section V. – Coverage Decisions and Exclusions

National and Local Coverage Determinations

Introduction to National Coverage Determinations. The HHS Secretary is authorized to make Medicare national coverage determinations (NCDs) to permit...
payment for any items and services that are reasonable and necessary for the diagnosis and treatment of illnesses and injuries, or to improve the functioning of a malformed body part, within a broad range of categories that are not specifically mentioned in Title 18 of the Social Security Act.

**Procedures for Developing a National Coverage Determination.** The term “national coverage determination” means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under title 18 of the Social Security Act (Medicare), but does not include a determination of what code, if any, is assigned to a particular item or service covered under Medicare or a determination with respect to the amount of payment made for a particular item or service so covered.

**Implementation of National Coverage Determinations.** After CMS approves a national coverage determination (NCD) request, the agency must make coding and payment level determinations and give claims processing instructions to CMS systems maintainers and contractors to ensure the accuracy of provider payments based on the new NCD. The Medicare Evidence Development Coverage Advisory Committee (MedCAC) advises CMS about the adequacy and conclusions of scientific evidence on an NCD, including any areas of controversy.

**Procedures for Developing a Local Coverage Determination.** Local coverage determinations (LCDs) are developed by Medicare contractors as administrative and educational tools to assist providers, physicians and suppliers with submitting correct claims for payment of reasonable and necessary items and services.

**Appeal of National and Local Coverage Determinations.** An administrative law judge (ALJ) may not review, disregard or otherwise set aside national coverage determinations (NCD); these reviews are conducted by the HHS Departmental Appeals Board (DAB). Local coverage determinations are reviewed by ALJs, Medicare contractors, and the DAB.

**Clinical Trials.** Medicare pays for most routine patient costs during qualified clinical trials. CMS, through the national coverage determination (NCD) process, and through an individualized assessment of benefits, risks, and research potential, may determine that certain items and services for which there is some evidence of significant medical benefit, but for which there is insufficient evidence to support a “reasonable and necessary” determination, are only reasonable and necessary when provided in a clinical trial that meets the requirements defined in that NCD. CMS’ Clinical Research Policy outlines criteria for coverage.

**National Coverage Determinations Announced.** National coverage determinations (NCDs) are published in the Medicare National Coverage Determinations Manual. The annotations to this section describe specific NCDs which are representative of NCDs. A full list of all NCDs is provided at [http://www.cms.gov/medicare-coverage-database/indexes/](http://www.cms.gov/medicare-coverage-database/indexes/).

**Comparative Effectiveness Research.** Comparative effectiveness research compares the benefit and harm of different interventions and strategies to prevent, diagnose, treat and monitor health conditions; the purpose of the research is to develop and disseminate evidence-based information to improve health outcomes. A 2009 federal law provides funding to agencies, including HHS, for this research.

**Exclusions from Coverage**

**Introduction to Exclusions.** A number of items and services are specifically excluded by statute from Medicare coverage. A current listing of all national coverage determinations is provided at [http://www.cms.gov/medicare-coverage-database/](http://www.cms.gov/medicare-coverage-database/).

**Services Not Reasonable and Necessary.** Items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body part, are excluded from Medicare coverage. Covered services and non-covered services, including services required as a result of non-covered services, are explained.

**No Legal Obligation to Pay.** Items and services furnished for which there is no legal obligation to pay, and that no other person (by reason of the individual’s membership in a prepayment plan or otherwise) has a legal obligation to provide or pay, are excluded from Medicare coverage.

**Government Paid Benefits.** In general, Medicare does not pay for items and services that are paid directly or indirectly by a governmental entity; however, Medicare does pay for some items and services furnished by specific government programs, including the Veterans Administration, TRICARE, the Indian Health Service, and various federal government providers.

**Services in Foreign Countries.** Items and services that are provided outside the United States are not covered by Medicare, with four exceptions.

**War Claims.** Items and services that are required as a result of war, or of an act of war that occurs after the effective date of a beneficiary’s current coverage for Part A or Part B benefits, are not covered by Medicare.

**Personal Comfort Items.** Personal comfort items that do not contribute meaningfully to the treatment of an
illness or injury or the functioning of a malformed body part are excluded from Medicare coverage under both Parts A and B, except as necessary for the palliation or management of terminal illness, under the hospice benefit.

**Checkups and Immunizations.** Medicare pays for an initial physical provided during the first year of a beneficiary’s Medicare eligibility, for annual “personalized prevention plan” services, and for flu, pneumonia, and hepatitis B vaccines. All other routine physical checkups and immunizations are excluded from Medicare coverage.

**Eye, Ear, and Foot Care.** Medicare does not cover routine eye, ear, and foot care services, with certain exceptions. **Cosmetic Surgery.** Cosmetic surgery aimed at improving appearance is excluded from coverage under both Medicare Parts A and B. Cosmetic surgery required for a therapeutic purpose such as the prompt repair of an accidental injury or the improved functioning of a malformed body part is covered, even if it also serves a cosmetic purpose.

**Charges by Immediate Relatives and Household Members.** Medicare does not pay for charges by immediate relatives of a beneficiary or by members of his or her household. This bars Medicare payment for personal services of physicians or suppliers that would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person.

**Dental Services.** Items and services for the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth are generally not covered by Medicare.

**Services Not Provided In-House.** Medicare requires hospitals and skilled nursing facilities to provide all services in-house or “under arrangements” so that the services may be paid under applicable prospective payment systems.

**Custodial Care: In General.** Custodial care services provided in hospitals, nursing homes, and elsewhere are excluded from Medicare coverage, except for hospice care services. Even if a patient’s stay in a hospital or skilled nursing facility is custodial, some individual services may still be covered under Medicare Part B if they are reasonable and necessary.

**Custodial Care in Hospitals.** Custodial care is generally excluded from Medicare coverage by law under both Parts A and B, but some care that would seem to be custodial care, such as rehabilitation care, pregnancy management services, as well as active treatment for patients that otherwise would require only custodial care, is covered by Medicare.

**Custodial Care in Skilled Nursing Facilities.** Medicare covers skilled nursing facility care if patients require reasonable and necessary skilled nursing care, on a daily and inpatient basis.

**Inpatient Care in Psychiatric Hospitals.** Medicare payment for inpatient psychiatric hospital services is made only for “active treatment” that can reasonably be expected to improve the patient’s condition.

**Medicare As Secondary Payer.** Under the Medicare Secondary Payer (MSP) exclusion, Medicare’s liability for payment is secondary to that of workers’ compensation, an employer group health plan, or the no-fault/liability insurer.

**Workers’ Compensation.** Medicare does not pay for any items and services paid for by a workers’ compensation law or plan, including black lung benefit programs. The intermediary or carrier must identify possible workers’ compensation claims to prevent conditional overpayment.

**Automobile and Liability Insurance.** Medicare payment is excluded for items and services if payment can be expected under an automobile or liability insurance policy, including a self-insured plan, or under no-fault insurance. Generally, primary insurers must be billed first by carriers/intermediaries.

**Employer Group Health Plans.** Medicare is the secondary payer for employees entitled to it based on age, disability, and (for a limited period of time) end-stage renal disease, when there is alternate insurance coverage, and any duplicate/conditional Medicare payments are subject to recovery.

**Excluded Drugs and Biologicals.** Drugs and biologicals that are ordinarily furnished by the hospital for the care and treatment of inpatients are covered under Medicare and Medicaid. Unless approved by CMS, drugs that are not FDA-approved are not covered.

**Services Provided by Excluded Individuals or Entities.** Medicare will not pay anyone who has been excluded from Medicare due to program abuses, except in emergency situations. Also, Medicare will not pay for items or services furnished at the medical
Section VI.—Prospective Payment Systems

Inpatient Hospital PPS

Introduction to the Inpatient Prospective Payment System. Due to the increasing costs and inefficiency of the Medicare cost-based reimbursement system for inpatient hospitals, Congress enacted legislation creating an inpatient prospective payment system (IPPS), effective October 1, 1983. The IPPS provides a single payment amount for each type of case, identified by the diagnosis-related group into which each case is classified.

IPPS Annual Final Rule Summaries. The payment rates and policy changes applicable to the inpatient prospective payment system (IPPS) are issued as final rules by Medicare prior to the beginning of each fiscal year from 1986 to the present time.

IPPS Legislation Summaries. Over the last 28 years, Congress has several times enacted legislation to amend the Social Security Act sections governing the inpatient prospective payment system (IPPS).

Transition to IPPS. The inpatient prospective payment system (IPPS) was phased in over a four-year period from October 1, 1983 until October 1, 1987, during which reimbursement was based on a blend of the new IPPS and the hospital’s actual costs during a base-year period.

Hospitals Subject to IPPS. The inpatient hospital prospective payment system (IPPS) applies to all short term, acute-care hospitals unless they are specifically excluded from IPPS under the law. Excluded hospitals are: psychiatric, children’s, rehabilitation, long-term care, cancer, Veterans Administration, and those outside the United States. There are special rules for hospitals in Puerto Rico.

Services Subject to IPPS. The inpatient hospital prospective payment system (IPPS) reimburses hospitals for their operating costs, which include costs for routine services, ancillary services, preadmission services, intensive care unit services, and malpractice insurance.

Diagnosis-Related Groups (DRGs) and Medicare Severity DRGs (MS-DRGs). Medicare’s inpatient prospective payment system’s (IPPS) GROUPER program classifies each patient’s case into a diagnosis-related group (DRG) based on information in the beneficiary’s bill, including principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status. The DRG assignment determines the payment the hospital receives. Starting in 2008, DRGs became Medicare Severity DRGs (MS-DRGs) to better reflect severity of illness.

Medicare Payment Amount. The total payment for inpatient hospital services furnished to a Medicare beneficiary under the inpatient prospective payment system (IPPS) is the sum of the payments for: operating costs, capital-related costs, additional costs such as outlier amounts, and new medical services and technologies. Some costs may not be included in IPPS payments. Medicare calculates a “standardized amount” for payment and updates it annually.

Geographic Classification. CMS defines hospital labor market areas for the inpatient prospective payment system (IPPS) based on the Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget (OMB), resulting in a high wage index for some areas and a low wage index for others, and in rural and urban classifications.

Medicare Geographic Classification Review Board. The Medicare Geographic Classification Review Board (MGCRB) issues decisions on the geographic reclassification, or redesignation, of hospitals as rural or urban for prospective payment system (PPS) purposes. Groups of hospitals and multi-campus hospitals may apply for reclassification. Hospitals seeking reclassification must prove: close proximity, comparable costs and comparable wage costs. There are special exceptions for rural referral centers and disproportionately large urban hospitals.
**Discharges and Transfers.** Payment for services under the inpatient prospective payment system (IPPS) differs according to whether the patient is “discharged” or “transferred.”

**Outliers.** Medicare provides extra “outlier” payments in the inpatient prospective payment system for extraordinarily costly cases. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold, which is determined each year by CMS. Hospital-specific cost-to-charge ratios are applied to the covered charges for a case to determine whether costs exceed the fixed-loss outlier threshold. Payments are then made based on a marginal cost factor, which is a percentage of the costs above the threshold.

**Hospital Quality Initiative.** The Hospital Quality Initiative (HQI) includes a number of programs aimed at improving patient care and providing quality information to consumers and others. Under the Inpatient Quality Reporting (IQR) program, hospitals paid by the inpatient prospective payment system (IPPS) receive reduced reimbursement for failure to submit quality data to CMS; under the value-based purchasing program, these hospitals receive reduced reimbursement for failure to meet quality measures; and, under the hospital readmission reduction program, these hospitals receive reduced reimbursement for excessive readmission of patients with certain conditions.

**Hospital-Acquired Conditions; “Never” Events.** CMS will deny payment for hospital-acquired conditions (HACs), or “never” events.

**Capital-Related Costs.** Medicare payment for capital-related costs for all inpatient prospective payment system (IPPS) hospitals, except new hospitals, is based solely on the standard federal rate.

**Indirect Costs of Medical Education.** Inpatient prospective payment system (IPPS) teaching hospitals receive a payment for the indirect costs of medical education (IME), designed to cover the increased operating and patient care costs associated with teaching programs.

**Direct Costs of Graduate Medical Education.** Hospitals and hospital-based providers receive payment for training residents in approved direct graduate medical education (GME) residency teaching programs, which are “passed through” the inpatient prospective payment system (IPPS). Payments are based on a prospectively determined per-resident amount.

**Disproportionate Share Hospitals.** An adjustment to diagnosis-related group (DRG) payment is made for disproportionate share hospitals (DSH) that: (1) serve a significantly disproportionate number of low-income patients, or (2) are located in an urban area, have 100 or more beds, and can demonstrate that more than 30 percent of their revenues are derived from state and local government payments for indigent care not covered by Medicare or Medicaid. The DSH adjustment is calculated by either the “Pickle method” or the “Medicare fraction/Medicaid fraction” method, which is the subject of current litigation. DSH payments will be revised in fiscal year 2014 under the Patient Protection and Affordable Care Act.

**Rural Hospitals.** Congress has provided special Medicare payments for qualifying rural hospitals that might otherwise suffer under the financial constraints of the prospective payment system (PPS). As of March 2002, rural hospitals that meet specific criteria may apply for special status as sole community hospitals (SCHs), critical access hospitals (CAHs) (formerly essential access community hospitals/rural primary care hospitals (EACH/RPCH), rural referral centers (RRCs), or Medicare-dependent hospitals (MDHs).

**Excluded Hospitals and Units.** Psychiatric, rehabilitation, and long-term care hospitals (and distinct part units) are exempt from the inpatient prospective payment system (IPPS) and have their own PPSs. Critical access hospitals, pediatric hospitals, and most cancer hospitals are exempt from IPPS and are reimbursed on a reasonable-cost basis subject to a ceiling on the rate of increase in inpatient costs. Other hospitals such as Veterans Administration hospitals, state hospitals, demonstration project hospitals, and hospitals that do not participate in Medicare but furnish emergency services to Medicare beneficiaries are not paid under the IPPS.

**Guarantee of Payment for Hospitals.** The guarantee of payment provision assures that payment will be made to a hospital for services it provides during the time it takes to ascertain whether the patient’s Medicare benefits have been exhausted. The guarantee includes cases in which benefits were exhausted prior to admission and cases for which a beneficiary had some inpatient benefits remaining at the time of his or her admission. Payment under the guarantee for those days after benefits are exhausted is made at the full rate without reduction for coinsurance.

**Hospital Outpatient PPS**

**Hospital Outpatient PPS Introduction.** Hospital services subject to the outpatient prospective payment system (OPPS) include Medicare Part B services furnished to hospital outpatients and partial hospitalization services furnished by community mental health centers. The Balanced Budget Act of 1997 established the OPPS to replace the Medicare Part B cost-based system. Implementation was delayed until August 2000, and there was a three-year transition period until 2004.
OPPS Sites of Service. The outpatient prospective payment system (OPPS) applies to covered hospital outpatient services, with some exceptions. Hospitals or distinct parts of hospitals, as well as cancer hospitals, that are excluded from the inpatient prospective payment system (IPPS) are included in OPPS when they furnish outpatient services. Partial hospitalization services in community mental health centers are also paid under OPPS.

Provider-Based Status. A provider-based entity is a provider of healthcare services or a rural health center that is created and acquired by a main provider under the name, ownership, and administrative and financial control of the main provider. A provider-based entity is the specific facility that serves as the site of services, and it may claim Medicare/Medicaid reimbursement. Provider-based determinations are made for payment purposes because a provider-based facility can be paid significantly more than a free-standing facility. CMS requires that a facility meet standards that establish that it is an integral and subordinate part of the main provider.

Attestation and Reporting Provider-Based Status to CMS. A provider that is seeking provider-based determination for an entity may submit an attestation to CMS that the entity has met the specific requirements applicable for provider-based status and any further requirements for that specific entity. The main provider should report to CMS any material change in the relationship between it and any provider-based entity. If CMS learns that a provider has incorrectly treated an entity as provider-based and the provider did not request a determination of provider-based status from CMS, the agency may review cost reports and recover overpayments.

Ambulatory Payment Classification System. Payment under the outpatient prospective payment system (OPPS) is based on groups of services called ambulatory payment classification (APC) groups, which consist of services that are comparable clinically and resource-wise. CMS updates APC groups, relative payment weights, and the wage and other adjustments annually to account for changes in medical practice and technology and to add new services and cost data.

New Technology APCs. New technology ambulatory payment classifications (APCs) cannot be accurately described by existing APCs and are not similar, either clinically or in terms of resource use, to an existing APC group and are not addressed by transitional pass-through provisions. New technology APCs are defined on the basis of costs and not the clinical characteristics of a service. The payment rate for each new technology APC is based on the midpoint of a range of costs. Beneficiary coinsurance is 20 percent of the APC payment rate.

APC Payment Rates and Adjustments. Payment under the outpatient prospective payment system (OPPS) is made on a rate-per-service basis that varies according to the ambulatory payment classification (APC) to which the service is assigned. Each APC is assigned a relative weight that reflects the APC’s use of resources as compared to other APCs. The APC payment rates are calculated on a national basis and then adjusted by geographic areas. The payment rate or fee schedule amount for services and procedures in an APC is the product of a conversion factor and a relative weight for the year.

Reporting of Quality Data. Hospitals must submit data on the quality of care provided in their outpatient departments under the Hospital Outpatient Quality Data Reporting Program. Beginning in 2009, hospitals that fail to submit quality data from the previous year will receive the full market basket increase minus 2.0 percent.

Services and Costs Excluded From Coverage Under OPPS. CMS excludes from coverage under the outpatient prospective payment system (OPPS) those services already subject to an existing fee schedule or other prospectively determined payment rate such as: inpatient services; ambulance services; screening mammographies; most services for patients with end-stage renal disease; professional services of physicians and nonphysician practitioners; laboratory services; and durable medical equipment, orthotics, prosthetics, and prosthetic devices.

Outlier Payments. Outlier payments are additional payment for high-cost patients. The outpatient prospective payment system (OPPS) provides outlier payments for outpatient services for which a hospital’s charges, adjusted to cost, exceed a fixed multiple of the OPPS payment, as adjusted by pass-through payments. CMS determines the amount of this fixed multiple, the outlier threshold, and the percent of costs above the threshold that is to be paid under the outlier provision. For services furnished in 2004 or after, total outlier payments may not exceed three percent of the total projected payments for outpatient department services (the sum of Medicare and beneficiary payments).

Drugs, Biologicals and Radiopharmaceuticals Paid Separately. Although most drugs are packaged under the outpatient prospective payment system (OPPS), certain drugs such as higher cost drugs, chemotherapeutic agents, immunosuppressive drugs, orphan drugs, radiopharmaceuticals, some new drugs, and certain other drugs are paid separately. Their ambulatory payment classification (APC) codes are listed annually by CMS.

Transitional Pass-through Payments. The outpatient prospective payment system (OPPS) provides for tempo-
rary additional payments, called “transitional pass-through payments,” to hospitals for a period of two or three years for: current orphan drugs; current cancer therapy drugs and biologicals; current radiopharmaceutical drugs and biological products; and new or innovative medical devices, drugs, and biological agents. This allows for adequate payment of new and innovative technology until there is enough data to incorporate the costs for these items into the base ambulatory payment classification (APC) system. There are additional requirements for medical devices given transitional pass-through payment status.

Prohibition Against Unbundling of Hospital Outpatient Services. Separate payments for non-physician services furnished to hospital inpatients or outpatients are prohibited, unless the services are furnished by the hospital either directory or under arrangements. The services of physician assistants, nurse practitioners and clinical nurse specialists may be billed separately.

Beneficiary Copayment and Coinsurance under OPPS. The coinsurance amounts for outpatient services are based on which Ambulatory Payment Classification (APC) group the service is in. Each APC group has a predetermined beneficiary coinsurance amount, which must be between 20 and 40 percent of the APC payment rate. A copayment amount for an APC cannot exceed the Medicare inpatient hospital deductible for that year.

Claims Submission and Processing. For ambulatory payment classifications (APCs) to properly capture outpatient services furnished under the outpatient prospective payment system (OPPS), hospitals must assign Healthcare Common Procedure Coding System (HCPCS) codes and diagnosis codes, not simply revenue center codes, for services. Hospitals must report on the same claim all HCPCS codes for separately payable, non-repetitive hospital OPPS services, and charges for all services and supplies associated with services, that were furnished on the same date, subject to a three-day payment window exception. Repetitive Medicare Part B services furnished to a single individual by providers must be billed monthly (or at the conclusion of treatment).

Inpatient Rehabilitation Facility PPS

Introduction. The inpatient rehabilitation facility (IRF) prospective payment system (PPS), which applies to rehabilitation hospitals and units that are exempt from inpatient PPS, became effective January 1, 2002. Prior to the implementation of the IRF PPS, IRFs were paid on a reasonable cost-based method. There was a blended payment transition period for IRFs until 2007 as well as a hold-harmless period for certain rural IRFs until 2009.

Classification as an Inpatient Rehabilitation Facility. Inpatient rehabilitation facilities (IRFs) are excluded from the diagnosis-related group (DRG)-based acute care hospital prospective payment system (PPS). A minimum percentage (compliance threshold) of the facility's total inpatient population must require intensive rehabilitative services for at least one of 13 specified conditions.

Outlier payments are additional payment for high-cost patients.

Patient Assessment for IRF Services. Inpatient rehabilitation facilities (IRFs) must complete the IRF patient assessment instrument (IRF-PAI) upon admission and discharge for all Medicare Part A fee-for-service patients who are inpatients or who are admitted or discharged on or after January 1, 2002. The admission assessment is used to place a patient in a case-mix group (CMG) and the discharge assessment is used to determine the relative weighting factors of comorbidities. As of January 1, 2010, there must be documentation in the patient’s medical record that the patient needs intensive inpatient rehabilitation.

IRF Payment Rate. The payment unit for the inpatient rehabilitation facility prospective payment system (IRF PPS) is referred to as a discharge. IRF PPS rates encompass inpatient operating costs and capital costs, including routine and ancillary costs, of furnishing covered rehabilitation services, plus costs of bad debts and blood clotting factors. Payment rates are calculated annually using relative weights to account for variations in resource needs in case-mix groups (CMGs).

IRF Payment Adjustments. The inpatient rehabilitation facility prospective payment system (IRF PPS) adjusts payments on a case-by-case basis with facility-level, case-level, and outlier adjustments.

Outpatient Rehabilitation Facility PPS

Introduction. Comprehensive outpatient rehabilitation facilities (CORFs) are paid under a prospective payment system (PPS). Since 1999, the Medicare Physician Fee Schedule (MPFS) has paid for outpatient physical therapy, outpatient speech-language pathology, and occupational therapy services furnished by or under arrangements with: rehabilitation agencies; outpatient
physical therapy providers; hospitals providing services to outpatients and inpatients who are not in a covered Part A stay; skilled nursing facilities (SNFs) providing services to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF; and home health agencies providing services to those not in a home health plan of treatment.

**Cap on Payment for Outpatient Rehabilitation Therapy.** Since 2003, caps have been placed on payment for outpatient rehabilitation therapy. The therapy caps consist of two limitations, one for physical therapy and speech-language pathology services and the other for occupational therapy.

**Long-Term Care Hospital PPS**

**Introduction.** In long-term care hospitals (LTCHs) the average Medicare inpatient length of stay is greater than 25 days. Services covered under the LTCH prospective payment system (PPS) include comprehensive rehabilitation, respiratory therapy, cancer treatment, head trauma management, pain management, and all other necessary covered services, either directly or under arrangements. Payment is made on a per-discharge basis. Each patient is classified into a medical severity long-term care diagnosis-related group (MS-LTC-DRG) which is the same CMS diagnosis-related group (DRG) used under the hospital inpatient PPS but weighted to reflect the resources required to treat the medically complex patients treated at LTCHs.

**Payment Under the LTCH PPS.** Effective October 1, 2002, long-term care hospitals (LTCHs) are reimbursed under the LTCH prospective payment system (PPS), which provides for an annual single, standard payment rate for both operating and capital costs. The LTCH PPS had a five-year phase-in period, ending in September 2007. An outlier payment is available. Starting in 2014, LTCHs that fail to report on quality measures will have a 2 percent reduction their annual market basket update.

**LTCH Location.** A long-term care hospital (LTCH) that is located within an acute care hospital, or on the same campus as buildings used by another hospital, is referred to as a co-located hospital or a hospital-within-a-hospital (HwH), and it must meet certain LTCH PPS payment criteria. LTCH satellite facilities provide inpatient services in the same building or in one or more buildings located on the campus of an acute care hospital, but are owned by a separate existing LTCH. Under the 25 percent rule, HwHs and satellite LTCHs may admit up to 25 percent of their patients from their host hospital and be paid under the LTCH PPS.

**Quality Improvement Organization (QIO) Review.** Quality Improvement Organizations (QIOs) review services and items provided to Medicare beneficiaries by hospital staff, physicians and other healthcare practitioners. All hospitals, including long-term care hospitals (LTCHs), are required to have an agreement with a QIO as a condition of participation in the Medicare program. Every QIO either must be sponsored by a significant number of physicians actively practicing in the QIO service area, or must have available to it the services of a sufficient number of area physicians to assure adequate peer review.

**Psychiatric Hospitals and Units**

**Introduction.** Since 2005, all inpatient psychiatric services at psychiatric hospitals and psychiatric hospital units have been paid under an inpatient psychiatric facility prospective payment system (IPF PPS). The per day (per diem) IPF PPS rate is adjusted by coded patient-level adjustments and by facility level adjustments such as geographic wage index factors. The IPF PPS also recognizes the higher costs of early days in psychiatric stays, and it includes outlier and interrupted stay adjustments.

**IPF PPS Per Diem Payment Factors.** CMS developed the inpatient psychiatric facility prospective payment system (IPF PPS) to pay providers a per diem amount per patient, and the system includes a tiered day structure to reflect varying costs per stay and an

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interrupted stay provision, to reflect the costs of patients moving in and out of facilities. The IPF PPS per diem payments reflect labor and capital-related costs. The agency also employed a case-mix regression analysis of the relationship between per diem costs and patient and facility characteristics to determine other factors that statistically affect costs.

**Inpatient Psychiatric Facility Adjustments.** Per diem payments made to providers under the inpatient psychiatric facility (IPF) prospective payment system (PPS) are adjusted to reflect facility characteristics, including the area wage index, a rural hospital adjustment, a teaching facility adjustment, an emergency department adjustment, and a cost of living adjustment for IPFs in Alaska and Hawaii.

**Inpatient Psychiatric Facility Patient Adjustments.** The inpatient psychiatric facility (IPF) prospective payment system (PPS) adjusts reimbursement to providers for a number of patient-related factors, including case complexity, comorbidity, and age. An outlier adjustment for particularly costly care is also available.

**Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program.** Beginning in fiscal year 2014, inpatient psychiatric facilities are required to submit data on specified quality measures that will be selected from those endorsed by qualified consensus-based entities or established by a different process under PPACA §3004. Facilities that do not submit quality data will be subject to a 2.0 percent reduction in the annual market basket update. [Soc. Sec. Act §1886(s)(4), as amended by PPACA §10322(a).]

### End-Stage Renal Disease Program

**Introduction.** Effective January 1, 2011, end-stage renal disease (ESRD) prospective payments are made under a bundled system, which includes payment for most drugs, biologicals, and tests. The new ESRD PPS accounts for low-volume ESRD facilities and costly outlier cases, and has patient case-mix adjustments and separate case-mix adjustments for pediatric patients. Prior to the bundled system implementation, outpatient maintenance dialysis services furnished to Medicare beneficiaries, in outpatient facilities and at home, were paid under a composite rate prospective payment system (PPS).

**ESRD Site of Service under the Composite Rate PPS.** Different dialysis payment rules apply depending on the setting of the service, whether in an inpatient setting, at home, in skilled nursing facilities, or in outpatient facilities.

**Outpatient ESRD Payments under the Composite Rate PPS.** Under the previous composite rate end-stage renal disease (ESRD) prospective payment system (PPS), there were two base composite rates, one for hospital-based ESRD facilities and a lower rate for independent (freestanding) facilities. Methods and rules for reimbursement of end-stage renal disease (ESRD) services and transplant services are currently in transition from a composite rate method to a prospective payment system (PPS). Effective January 1, 2011, ESRD facilities are compensated under a rate blending the composite and the PPS methods. The blend will change each year so that as of January 1, 2014, all ESRD services will be paid under the PPS. Dialysis facilities may choose to be compensated only under the PPS as of January 1, 2011.

**ESRD Laboratory Tests Under the Composite Rate PPS.** With some exceptions, laboratory tests for hemodialysis, intermittent peritoneal dialysis (IPD), and continuous cycling peritoneal dialysis (CCPD) are included in the end-stage renal disease (ESRD) composite rate payment. Other tests are subject to the laboratory fee schedule limits and paid separately. CMS policy permits separate payment for tests when more than 50 percent of all tests on a date of service are tests not included in the composite payment rate. Some tests provided beyond the normal frequency are covered when based on medical necessity.

**ESRD Drugs and Biologicals.** Medicare pays for drugs medically necessary for end-stage renal disease (ESRD) patients if they are furnished in approved ESRD facilities for renal dialysis services under the bundled payment rate system.

**Physician Reimbursement for ESRD Services.** Physicians furnish two types of services—routine professional services and administrative services—in connection with end-stage renal disease (ESRD) treatment. Routine professional services may be paid under the initial method (IM) or monthly capitation payment (MCP). Administrative services are consid-
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Ambulatory Surgical Centers

Introduction. Surgical procedures performed in an ambulatory surgical center (ASC), except those in a defined list of excluded procedures, when provided on or after January 1, 2008, are paid by Medicare under an ASC prospective payment system (PPS). The covered procedures have codes that are clinically similar to procedures that CMS has determined: (1) do not pose a significant safety risk; (2) would not require a stay at an ASC after midnight on the day of the procedure; and (3) are separately paid under the outpatient PPS. CMS annually publishes an illustrative list of covered surgical procedures and radiology procedures as well as a list of procedures excluded from ASC coverage.

ASC Payment System Rates. Effective in 2008, a new ambulatory surgical center (ASC) prospective payment system (PPS) takes into account the lower costs of ASC surgery relative to hospital outpatient department surgery. An ASC system conversion factor looks at outpatient PPS rates to determine unadjusted ASC payment rates. The ASC system then adjusts rates yearly for geography and inflation. Multiple procedures are discounted.

Hospice Reimbursement

Introduction. Hospices are paid a specific amount for each day of beneficiary care. There are four different daily reimbursement amounts depending on the type of care provided each day. The daily amounts are adjusted to reflect local wages differences. The total amount a hospice can receive for each beneficiary is capped at an annual level. Reimbursement amounts are revised annually. There are special rules for physician reimbursement.

Hospice Wage Index Tables. The daily payment rates for routine home care, continuous home care, inpatient respite care, and general inpatient care are adjusted by CMS for regional differences in wages, using annually updated wage index tables.

Home Health PPS

Introduction. Effective October 2000, Medicare pays home health agencies (HHAs) for providing care to beneficiaries during 60-day episodes of care, which may be limited. The formula for payments made under the home health prospective payment system (HH PPS) is based on a number of factors, including the type and severity of the patient’s condition, the type and number of services used, and the number of therapy visits. Payment is adjusted based on labor costs in the geographic area where services are furnished. The diagnosis groups used in the HH PPS are called home health resource groups (HHHRG).

Payment for a Home Health Episode of Care. Under the home health prospective payment system (HH PPS), a standardized payment, subject to several adjustments, is made for each 60-day episode of care an eligible beneficiary receives from a home health agency (HHA) and covers certain specified costs. Billing for HHA services is consolidated, and bills are submitted to intermediaries for anticipated payment and for final payment. HHAs must give beneficiaries specific advance beneficiary notices when care is reduced or terminated.

Determination of Standard HH PPS Payment Amount. CMS used home health agency (HHA) cost report data to compute the mean national HH cost-per-visit and multiplies it by the national mean utilization to arrive at a standard unadjusted national 60-day episode payment rate. The agency then adds the cost of nonroutine medical supplies and adjusts for reporting costs. CMS limits the total standard payment amount available under the home health prospective payment system (HH PPS) to the total amount that would have been paid in the absence of such a system.

Skilled Nursing Facility PPS

Introduction. Medicare has paid skilled nursing facilities (SNFs) under a prospective payment system (PPS) since July 1, 1998. The SNF PPS pays a federal per-day rate, called a per diem rate, for covered SNF services given to Medicare fee-for-service beneficiaries (those not enrolled in managed care programs). The rate is adjusted for various factors and updated each year, as will be explained in detail in subsequent paragraphs. The PPS covers routine SNF services, including physical, occupational, or speech-language therapy, but it does not cover payment for certain services such as physician, nurse practitioner, clinical nurse specialist and physician assistant services.

SNF PPS Resident Classification System. The federal skilled nursing facility (SNF) prospective payment system (PPS) payment rate is case-mix adjusted to account for the relative resource utilization of different patients, measuring the intensity of care and services required and then translating them into Resource Utilization Groups (RUGs). RUGs are also the basis for the relative payment weights used for standardization of the SNF PPS rates. Care provided directly to, or for,
a patient is represented by a RUG index score based on the amount of staff time needed, weighted by salary levels. RUGs are updated periodically by CMS; currently there are 66 groups in RUG IV. The Minimum Data Set (MDS) is a resident assessment instrument used by SNFs to assess patient needs and classify patients into RUG groups.

**SNF PPS Per Diem Federal Rates.** CMS pays skilled nursing facilities (SNFs) under a per diem (per day) prospective payment system (PPS) covering all costs (routine, ancillary, and capital) related to the services furnished to SNF beneficiaries under Part A of the Medicare program. To calculate SNF PPS per diem rates each year, CMS uses the following data: SNF cost reports; a wage index to adjust for geographic area wage differences; the most recent projections of cost increases from the SNF market basket index; resident Resource Utilization Group (RUG) case-mix information; and Medicare Part B SNF claims data. Per diem rates are then adjusted by CMS to be facility-specific.

**SNF Consolidated Billing Requirements and Part B Payments.** With a few exceptions, the billing for all skilled nursing facility (SNF) services covered either under Medicare Part A or Medicare Part B is consolidated, as required by the SNF prospective payment system (PPS). Consolidated billing includes billing for most physical, occupational and speech-language therapy services. Physician and other practitioner billing is excluded from consolidated billing, and there are special rules for: telehealth services, dialysis services, durable medical equipment, and ambulance services.

**Periodic Interim Payments and Accelerated Payments.** A skilled nursing facility (SNF) paid under the SNF prospective payment system (PPS) may receive biweekly periodic interim payments (PIPs) if it meets certain requirements and receives intermediary approval. SNFs also may receive PIPs for costs such as bad debts, which are paid outside of the SNF PPS. Accelerated payments are also made to SNFs that experience exceptional situations or financial difficulties due to intermediary payment delays.

**Swing-Bed Hospitals.** Certain small rural hospitals may enter into Medicare swing-bed agreements, using their beds to provide either acute or skilled nursing facility (SNF) care, as needed. Effective July 2, 2002, swing-bed facilities that are not critical access hospitals (CAHs) are paid under the SNF prospective payment system (PPS). For CAHs, Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. A swing-bed facility must be in substantial compliance with all SNF requirements, meet all the conditions of participation applicable to a Medicare-certified hospital, and not have had a swing-bed approval terminated within two years of a swing-bed application. CMS developed a unique Minimum Data Set (MDS) for swing-bed hospitals, which was updated in 2010.

**Medical Review of SNF Data.** CMS is required to undertake a medical review process to examine the effects of the skilled nursing facility (SNF) prospective payment system (PPS) on the quality of SNF services. For these reviews, CMS contractors select SNFs at random, on a pre-payment, targeted basis, looking at Minimum Data Set (MDS) data. SNFs also may send bills for review when beneficiaries dispute a SNF opinion that Medicare will not cover services or when SNFs require a Medicare denial of payment notice.

### Federally Qualified Health Center

**Introduction.** CMS must create a prospective payment system (PPS) for services provided by federally qualified health centers (FQHCs) to account for the type, intensity, and duration of services, effective for cost reporting periods beginning on or after October 1, 2014. The PPS must include a process to appropriately describe FQHC services and establish payment rates for specific payment codes, and it may also include adjustments, such as geographic adjustments.

**Critical Access and Other Excluded Hospitals

**Introduction.** Critical access hospitals (CAHs) are rural community hospitals that must provide 24-hour emergency services but are limited to 25 inpatient beds. CAHs are reimbursed by Medicare on a reasonable cost basis, at 101 percent of allowable costs, rather than on a prospective payment basis. CAHs must belong to rural health networks. Medicare covers CAH items and services similarly to those furnished in acute care hospitals. A CAH may provide acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient. Physician services, except certain anesthesia services, are not covered.

**Inpatient Reimbursement.** Critical access hospitals (CAHs) may choose to receive interim, biweekly payments and accelerated payments in addition to the yearly payment to settle the cost report. Geographic classifications affect CAH status, and use of electronic health technology will affect CAH reimbursement.

**Swing Beds and Distinct Part Units.** Swing-beds are inpatient beds in critical access hospitals (CAHs) that can be used interchangeably for either acute-care or skilled nursing care. There is no length of stay restriction for CAH swing-bed patients, who are considered to be CAH patients and not traditional skilled nursing facility (SNF) patients. Payment is on
a reasonable cost basis through the CAH, not through the SNF prospective payment system (PPS). CAH swing-bed facilities must be certified by CMS. CAH may establish psychiatric and rehabilitation distinct part units (DPUs), which are paid under the PPSs that would apply if the units were established in an acute care hospital.

Partial Hospitalization. Partial hospitalization programs (PHP) are structured to provide intensive psychiatric care, and they may be provided in critical access hospitals (CAHs). Payment is on a reasonable cost basis. Some professional services such as physician services are covered separately from PHP services, but other services such as clinical social worker services are bundled into PHP payment.

Outpatient Reimbursement. Critical access hospitals (CAHs) may elect either standard (cost-based) or optional reimbursement for outpatient services, and the latter includes 115 percent of the professional fee schedule for professional services. Cost-sharing applies. Each practitioner may choose whether to reassign billing rights to the CAH. There are special payment rules for: ambulance services, tests, certified registered nurse anesthetists, and on-call emergency room providers. Physicians rendering services in CAHs in Health Professional Shortage Areas (HPSAs) receive special payment incentives.

Indian Health Services. Clinics associated with hospitals and freestanding clinics that are owned and operated by the Indian Health Services (IHS) or that are tribally owned but IHS-operated are considered to be IHS and are authorized to bill only the selected carrier for Part B services. Other clinics associated with hospitals and freestanding clinics that are not considered to be IHS may bill the local Part B carrier for the full range of covered Medicare services.

Other Hospitals and Providers Excluded from PPS. Veterans’ administration hospitals, hospitals reimbursed under state cost control systems, hospitals reimbursed under demonstration projects, specialty hospitals such as cancer hospitals and physician-owned hospitals, and nonparticipating hospitals furnishing emergency services to Medicare beneficiaries are excluded from Medicare prospective payment systems (PPSs).

Alternative Payment Systems

Accountable Care Organizations. Accountable care organizations (ACOs) were mandated by the Patient Protection and Affordable Care Act (PPACA) to be created by HHS by January 1, 2012. ACOs are groups of providers and suppliers of services that work together and are jointly responsible for the cost and quality of care provided to Medicare fee-for-service beneficiaries. A number of program incentives are available to ACOs.

Demonstration Program on Payment Bundling. A demonstration project on bundling payments, which would make one payment to a provider for all services performed during an episode of care, is being implemented by the Center for Medicare and Medicaid Innovation as required by the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148). This demonstration program is meant to provide integrated care during an episode of care where a Medicare beneficiary is hospitalized for certain conditions and to improve the coordination, quality, and efficiency of services. In some instances, Medicare’s payment would be made to only one provider and other providers would be paid by the provider receiving Medicare funds.

Section VII. – Medicare Part C

Introduction. Medicare Advantage, or Medicare Part C, is the managed care part of the Medicare program. Private companies contract with CMS to offer similar—or in some cases enhanced—benefits to beneficiaries, compared with traditional fee-for-service Medicare benefits.

Participating Organizations. Participating Medicare Advantage (MA) organizations contract with CMS to offer MA plans. There are three basic types of MA plans: (1) coordinated care plans; (2) private fee-for-service plans; and (3) a combination of an MA medical savings account (MSA) plan and a contribution into an MA MSA.

Eligibility, Election and Enrollment. With the exception of individuals with end-stage renal disease (ESRD), any beneficiary who is entitled to Medicare Part A and enrolled under Part B may elect, during designated enrollment periods, to receive benefits through either the original Medicare fee-for-service program or a Medicare Advantage (MA) plan under contract with CMS.

Benefits and beneficiary Protections. A Medicare Advantage (MA) organization offering an MA plan must offer it to all Medicare beneficiaries residing in the service area of the plan; and, at a uniform premium, with uniform benefits and level of cost-sharing throughout the plan’s service area. In addition to basic benefits, an MA plan also may include mandatory and optional supplemental benefits.

Quality Improvement Program. For all types of plans that it offers, a Medicare Advantage (MA) organization must: (1) maintain a health information system that collects, analyzes, and integrates the data necessary
to implement its quality assessment and performance improvement program; (2) ensure that the information it receives from providers of services is reliable and complete; and (3) make all collected information available to CMS.

**Provider Relationships.** Medicare Advantage (MA) organizations have certain requirements and standards for their relationships with providers, including physicians, other health care professionals, institutional providers and suppliers, under contracts or arrangements or deemed contracts under MA private fee-for-service plans. Certain requirements also apply to noncontracting providers.

**Plan Approval: Bids, Premiums, and Related Information.** CMS regulates the bidding process for organizations that wish to participate in Medicare Advantage (MA). This section explains the requirements for the MA bidding payment methodology, including calculation of benchmarks by CMS, submission of plan bids by MA organizations, establishment of beneficiary premiums and rebates through comparison of plan bids and benchmarks, and negotiation and approval of bids by CMS.

**Payments to Medicare Advantage Organizations.** Advance monthly payments are made by CMS to Medicare Advantage (MA) organizations for coverage of original fee-for-service benefits for an individual in an MA payment area for a month. The rules for making payments to MA organizations offering local and regional MA plans are discussed in this section, including calculation of MA capitation rates and benchmarks, conditions under which payment is based on plan bids, adjustments to capitation rates (including risk adjustment), and other payment rules.

**Provider Sponsored Organizations.** To be authorized to contract as a Medicare Advantage (MA) plan, a provider sponsored organization (PSO) must: (1) obtain a waiver of state licensure; (2) meet the definition of a PSO; (3) be effectively controlled by the health care provider or by one or more of the affiliated providers; and (4) be capable of delivering to Medicare enrollees the range of services required under a CMS contract.

**Compliance with State Law and Preemption.** Each Medicare Advantage (MA) organization must be licensed under state law as a risk-bearing entity eligible to offer insurance in each state in which it offers one or more MA plans. This federal preemption, however, does not apply to state licensing or solvency laws.

**Medicare Advantage Regional Plans.** A Medicare Advantage (MA) regional plan must have a service area consisting of an entire MA region and must include a single deductible and a catastrophic limit on out-of-pocket expenditures for benefits under the original Medicare fee-for-service program. A “blended benchmark” amount is computed by HHS for each region, allowing each MA organization to influence the final benchmark amount, through its plan bid amount.

**Applications and Contracts.** In order to qualify as a Medicare Advantage (MA) organization, enroll beneficiaries in any plans it offers, and be paid on behalf of Medicare beneficiaries enrolled in those plans, an MA organization must enter into an annual contract with CMS. Entities seeking a MA contract with CMS must submit a Notice of Intent to Apply and fully complete all parts of a certified application.

**Change in Facility Ownership and Leasing.** A Medicare Advantage (MA) organization that has a Medicare contract in effect and is considering a change in ownership must notify CMS at least 60 days before the effective date of the change, provide updated financial information, and discuss the financial impact of the change of ownership.

**Grievances, Organizational Determinations, and Appeals.** A Medicare Advantage (MA) organization must have a procedure for making timely organizational determinations regarding enrollee benefits, the amount that the enrollee is required to pay, and a process for reconsidering its determinations. Each organization also must provide meaningful procedures for timely hearing of grievances between enrollees and the organization or any other entity through which the organization provides health care services.
Contract Determinations and Appeals. This section establishes the procedures for making and reviewing the following contract determinations: (1) that an entity is not qualified to enter into a contract with CMS under Part C of Title XVIII of the Social Security Act; (2) to terminate a contract with a Medicare Advantage (MA) organization; (3) not to authorize a renewal of a contract with an MA organization; and (4) that an entity is not qualified to offer a specialized MA plan for special needs individuals.

Intermediate Sanctions and Civil Money Penalties. Intermediate sanctions that may be imposed on Medicare Advantage (MA) organizations include suspension of (1) enrollment, (2) payment, and (3) marketing activities. In addition to, or in place of, intermediate sanctions, CMS or the Office of Inspector General may impose civil money penalties up to $25,000 for each MA enrollee directly adversely affected by a deficiency or $25,000 for each determination.

Appeal Procedures for Civil Money Penalties. A Medicare Advantage (MA) organization dissatisfied with an initial CMS determination imposing a civil money penalty (CMP) has a right to a hearing before an administrative law judge (ALJ) and may request Departmental Appeals Board (DAB) review of the ALJ decision. Sponsors may also seek judicial review of a DAB decision imposing a CMP.

Marketing Requirements. A Medicare Advantage (MA) organization may not distribute any marketing materials, or election forms, or make such materials or forms available to individuals eligible to elect an MA organization unless at least 45 days before the date of distribution the organization has submitted the material or form to CMS for review; and CMS does not disapprove the distribution of the new material or form. The time period may be reduced to 10 days if the plan uses marketing materials that use, without modification, CMS proposed model language and format.

Medical Loss Ratio Requirements. Under the new medical loss ratio (MLR) requirements, for contracts beginning in 2014 or later, Medicare Advantage (MA) organizations are required to report their MLR, and are subject to financial and other penalties for a failure to meet a new statutory requirement that they have an MLR of at least 85 percent. The Affordable Care Act requires several levels of sanctions for failure to meet the 85 percent minimum MLR requirement, including remittance of funds to the Secretary, a prohibition on enrolling new members, and ultimately contract termination. The MLR is expressed as a percentage, generally representing the percentage of revenue used for patient care, rather than for such other items as administrative expenses or profit.

Section VIII.—Medicare Part D

Introduction. The Medicare Part D prescription drug program automatically provides a prescription drug benefit to beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual eligibles) unless Medicare has identified the individual as having other creditable coverage through an employer-based prescription drug plan. The benefit permits eligible individuals to choose from at least two prescription drug plans in their region, either a standard coverage plan or an alternative coverage plan with actuarially equivalent benefits.

Eligibility and Enrollment. To be eligible for prescription drug benefits under Part D, an individual must be entitled to Medicare benefits under Part A or enrolled in Medicare Part B and live in the service area of a Part D plan. An eligible individual may enroll in a prescription drug plan (PDP) during the specified regulatory enrollment periods by filing the appropriate enrollment form with the PDP or by using other CMS-approved enrollment mechanisms.

Benefits and Beneficiary Protections. The standard prescription drug benefit consists of coverage of covered Part D drugs subject to an annual deductible, 25 percent coinsurance up to an initial coverage limit, and catastrophic coverage after an individual incurs out-of-pocket expenses above a certain annual out-of-pocket threshold. A covered Part D drug is a drug that is included in a plan’s formulary, or treated as being included in a plan’s formulary as a result of a coverage determination or appeal, and obtained at a network or out-of-network pharmacy.

Cost Control and Quality Improvement Requirements. Part D sponsors must establish a drug utilization management program, quality assurance measures and systems, and a medication therapy management program (MTMP). The drug utilization management and MTMP requirements, however, do not apply to private fee-for-service Medicare Advantage plans offering qualified prescription drug coverage. Part D sponsors, prescribers, and dispensers must maintain a regulatory compliant electronic prescription drug program when transmitting prescriptions and prescription-related information.

Plan Approval: Submission of Bids and Monthly Beneficiary Premiums. Not later than the first Monday in June, each potential Part D sponsor must submit bids and other supplemental information for each Part D plan it intends to offer in the upcoming calendar year. Each bid must reflect a uniform benefit package, including premium and all applicable cost sharing for all individuals enrolled in the plan, and an estimate of
the average monthly revenue requirements to provide qualified prescription drug coverage.

CMS computes a national average monthly bid amount from approved bids in order to calculate the base beneficiary premium.

**Payments to Part D Plan Sponsors for Qualified Prescription Drug Coverage.** CMS makes the following payments to Part D plan sponsors: (1) monthly payments equal to the plan’s standardized bid, risk adjusted for health status, minus the monthly beneficiary premium; (2) monthly reinsurance subsidy payments based on either estimated or incurred allowable reinsurance costs with a final reconciliation to actual allowable reinsurance costs; and (3) payments for premium and cost sharing subsidies. CMS may issue lump-sum payments or adjust monthly payments in the following payment year based on the relationship of the plan’s adjusted allowable risk corridor costs to predetermined risk corridor thresholds in the coverage year.

**Organizational Compliance with State Law and Preemption by Federal Law.** Each prescription drug plan (PDP) sponsor must be organized and licensed under state law as a risk bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers a PDP. If unlicensed, the sponsor must obtain certification from the state that it meets a level of financial solvency that the state requires. CMS may waive the state licensure requirement if it determines that grounds for approval of the state licensing application have been met. CMS’ licensure and solvency standards supersede any state law or regulation other than state licensing or plan solvency laws.

**Coordination of Part D Plans with Other Prescription Drug Coverage.** Medicare Part D regulations: (1) apply to prescription drug coverage provided by Medicare Advantage prescription drug (MA-PD) plans offered by MA organizations; (2) establish waivers of Part D provisions applicable to MA-PD plans, employer-sponsored group PDPs, cost plans, and PACE organizations; and (3) set forth requirements for coordination of benefits with State Pharmaceutical Assistance Programs and other providers of prescription drug coverage. Medicare secondary payor provisions under Part C also apply to Part D sponsors and plans with respect to the offering of qualified prescription drug coverage.

**Application Procedures and Contracts with Part D Plan Sponsors.** An organization submitting an application to be a Part D sponsor for a particular contract year must first submit a completed Notice of Intent to Apply to CMS. To become a Part D plan sponsor, an entity must: (1) complete a certified application that includes documentation of appropriate state licensure or state certification that the entity is able to offer health insurance or health benefits coverage that meets state-specified standards, or documentation of a federal waiver of state certification or licensure; and (2) describe thoroughly how the entity is qualified to meet all the prescription drug plan requirements.

**Change of Ownership or Leasing of Facilities During Contract Term.** A prescription drug plan (PDP) sponsor that has a contract with CMS and is considering a change in ownership must (1) notify CMS at least 60 days before the anticipated effective date of the change, and (2) provide updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization. If a PDP sponsor leases all or part of its facilities to another entity, the other entity does not acquire PDP sponsor status. If a PDP sponsor leases all of its facilities to another entity, the Part D contract terminates.

**Grievances, Coverage Determinations, Redeterminations, and Reconsiderations.** A Part D plan sponsor, for each Part D plan that it offers, must establish (1) a grievance procedure for addressing issues that do not involve coverage determinations; (2) a procedure for making timely coverage determinations, including determinations on requests for exceptions to a tiered cost-sharing structure or to a formulary; and (3) appeal procedures for issues that involve coverage determinations, including redeterminations and reconsiderations by an independent review entity.

**Contract Determinations and Appeals.** Administrative appeal procedures exist for a prescription drug plan (PDP) applicant or sponsor if CMS: (1) determines that the entity is not qualified to contract with CMS; (2) determines that the entity is not authorized to renew its contract; or (3) makes a determination to terminate its contract. CMS must give the sponsor written notice of the contract determination, specify the reasons for

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CMS is required to subsidize the monthly beneficiary premium and cost-sharing amounts incurred by Part D eligible individuals with lower income and resources.
the determination, and provide the right to request a hearing. Either CMS or a PDP sponsor that has received a hearing decision regarding a contract determination may request review by the Administrator.

Intermediate Sanctions. If CMS determines that a basis exists for the imposition of intermediate sanctions, the agency may suspend (1) enrollment of Medicare Part D beneficiaries; (2) payment to the sponsor for beneficiaries who are enrolled in the plan; and (3) all marketing activities to beneficiaries by a sponsor. Intermediate sanctions may include the imposition of civil money penalties. Before imposing intermediate sanctions, CMS must send a written notice to the sponsor stating the nature and basis of the proposed intermediate sanction, and the sponsor’s right to a hearing.

Premiums and Cost-Sharing Subsidies for Low-Income Individuals. CMS is required to subsidize the monthly beneficiary premium and cost-sharing amounts incurred by Part D eligible individuals with lower income and resources. The value of a life insurance policy and in-kind support and maintenance provided by a family member or church are exempted from income and resources for determination of eligibility for the low-income subsidy. Determinations of eligibility for subsidies are made by the state under the state Medicaid plan, or by the Commissioner of Social Security if the individual applies to the Social Security Administration.

Fallback Prescription Drug Plans. If CMS determines that eligible individuals in a prescription drug plans (PDP) region, or some portion of the region, do not have a choice of at least two qualified PDPs, CMS must designate the region or portion of a region as a fallback service area. Because of the abundance of PDPs, to date it has been unnecessary for CMS to designate any fallback service areas or solicit bids from fallback plans.

Payments to Sponsors of Retiree Prescription Drug Plans. For each qualifying covered retiree, the sponsors of qualified retiree prescription drug plans (PDPs) can receive a subsidy payment in the amount of 28 percent of the allowable retiree costs in the plan year attributable to gross retiree costs between the cost threshold and the cost limit. Retiree health coverage is considered to be a qualified retiree PDP if: (1) an actuarial attestation is submitted; (2) covered Part D eligible individuals are provided with creditable coverage notices; (3) records are maintained and made available for audit; (4) the sponsor has a written agreement with its health insurance issuer or group health plan regarding disclosure of information to CMS; and (5) the issuer or plan discloses to CMS the information necessary for the sponsor to comply with all regulatory requirements.

State Rules-Subsidy Eligibility Determinations and General Payment Provisions. State agencies are required to (1) make eligibility determinations and redeterminations for low-income premium and cost-sharing subsidies; (2) screen individuals who apply for subsidies for eligibility and offer enrollment for the programs under the State plan for those meeting the eligibility requirements; and (3) inform CMS of cases where eligibility is established or redetermined. Regular federal matching applies to the eligibility determination and notification activities for low-income subsidies.

Appeal Procedures for Civil Money Penalties. Initial determinations regarding the imposition of civil money penalties (CMPs) are made by CMS. CMS is required to mail notice of an initial determination to the affected party, setting forth the reasons for the determination, the effect of the determination, the party's right to a hearing, and information about where to file the request for a hearing. A Part D sponsor dissatisfied with an initial CMS determination imposing a CMP has a right to a hearing before an administrative law judge (ALJ), may request Departmental Appeals Board (DAB) review of the ALJ decision, and may also seek judicial review of the DAB decision.

Reopenings, ALJ Hearings, MAC Review, and Judicial Review. A reopening may be taken by: (1) a Part D plan sponsor to revise the coverage determination or redetermination; (2) an independent review entity (IRE) to revise the reconsideration; (3) an administrative law judge (ALJ) to revise the hearing decision; or (4) the Medicare Appeals Council (MAC) to revise the hearing or review decision. If the amount remaining in controversy after the IRE reconsideration meets the threshold requirement, an enrollee who is dissatisfied with the IRE reconsideration determination has a right to a hearing before an ALJ. An enrollee who is dissatisfied with an ALJ hearing decision or dismissal may request MAC review. An enrollee may obtain court review of a MAC decision. For an enrollee to request judicial review of an ALJ’s decision, the MAC must have denied the enrollee’s request for review.

Marketing Requirements. A Part D plan may not distribute any marketing materials or enrollment forms unless at least 45 days before the date of distribution the sponsor submits the material or form to CMS for review and CMS does not disapprove the distribution. The time may be reduced to 10 days if the plan uses marketing materials that use, without modification, CMS proposed model language and format. Marketing materials exclude ad hoc enrollee communications materials. Marketing materials developed for members of an employer group who are eligible for employer-sponsored benefits through the Part D sponsor are not subject to prior review and approval by CMS.
Coverage Gap Discount Program. After January 1, 2011, in order for coverage to be available under Medicare Part D for applicable drugs of a manufacturer, the manufacturer must: (1) participate in the coverage gap discount program (a 50 percent discount on the cost of applicable drugs to beneficiaries while in the “donut hole”); (2) enter into a discount program agreement with CMS; and (3) enter into a contract with a third-party administrator (CMS contractor) responsible for administering the requirements established by CMS to carry out the program. An exception to the discount may apply only if the Secretary of HHS determines that the availability of the applicable drug is essential to the health of beneficiaries enrolled in Part D.

Medical Loss Ratio Requirements. Under the new medical loss ratio (MLR) requirements, for contracts beginning in 2014 or later, Medicare Part D sponsors are required to report their MLR, and are subject to financial and other penalties for a failure to meet a new statutory requirement that they have an MLR of at least 85 percent. The Affordable Care Act requires several levels of sanctions for failure to meet the 85 percent minimum MLR requirement, including remittance of funds to the Secretary, a prohibition on enrolling new members, and ultimately contract termination. The MLR is expressed as a percentage, generally representing the percentage of revenue used for patient care, rather than for such other items as administrative expenses or profit.

Section IX.—Medicare Claims, Refunds, Overpayments, Underpayments

Medicare Claims

Introduction. Generally, payment for covered services under the Medicare program may be made on behalf of an individual to (1) a participating provider, or (2) to a nonparticipating hospital that has filed a statement of election to claim Medicare payment for all emergency services furnished during the calendar year or for services outside the United States on a case-by-case basis.

Request for Payment. Providers of services file the claim for payment and payment is made on behalf of beneficiaries directly to the providers. In the case of physicians and suppliers, payment may be made to the beneficiary or made on behalf of the beneficiary if the beneficiary has assigned Medicare payment to the physician or supplier. Medicare beneficiaries have the option to enter into private contracts that bypass the Medicare limitations on reimbursement for physicians and other health care practitioners.

Electronic and Paper Claims Submissions. All initial claims for Medicare reimbursement, except claims from small providers, must be submitted electronically in a standardized format. Every entity making electronic media claim submissions to the Medicare program is required to complete an Electronic Data Interchange (EDI) Enrollment Form.

National Standards for Routine Electronic Transactions. Uniform national standards for routine electronic health care transactions are established through rulemaking by the Secretary of HHS, implementing the standardization requirements imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Time Limitations for Filing Provider Claims. Claims must be received no later than one calendar year after the date of service. Claims with dates of service received later than one calendar year before the date of service will be denied by Medicare. Medicare contractors determine whether a claim has been filed timely and although a claim denied for untimely filing cannot be appealed by a provider, the provider may have an informal hearing with the Medicare contractor.

Time Limitation for Filing Medical and Other Claims. Medicare Part B claims must be received no later than one calendar year after the date of service. Claims with dates of service received later than one calendar year before the date of service will be denied by Medicare. Medicare contractors determine whether a claim has been filed timely and although a claim denied for untimely filing cannot be appealed by a provider, the provider may have an informal hearing with the Medicare contractor.

Request for Payment Signature Requirements for Beneficiaries and Their Representatives. All requests for payment must be signed by the beneficiary or the beneficiary’s representative unless the beneficiary has died. If the beneficiary is unable to execute a request for payment because of a mental or physical condition, the request may be executed on his or her behalf by a legal guardian, representative payee, relative, friend, representative of an institution providing him or her care or support, or of a governmental agency providing assistance.

Requirements for Payment of Claims for Deceased Beneficiaries. There are unique rules for signature and payment requirements in situations in which a beneficiary to whom a Medicare benefit is payable dies before a claim is filed or when he or she files a claim but dies before the claim is settled.
Diagnostic Codes. Physicians are required to use diagnostic codes for each item or service billed under Part B. The current coding system is the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); however, the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) will be adopted as standard code sets for coding diagnoses and inpatient hospital procedures, respectively. On September 5, 2012, the Office of the Secretary of HHS issued a final rule that delayed compliance with the adoption of ICD-10 code sets for one year, from October 1, 2013, to October 1, 2014.

National Provider Identifier System. CMS adopted the National Provider Identifier (NPI) in 2005 as the standard unique health identifier for health care providers, health plans and employers for use in filing and processing health care claims and other transactions. Medicare has required NPI reporting since May 23, 2008, when the use of the Unique Physician/Practitioner Identification Number (UPIN) by physicians and other qualified professionals was eliminated. HHS also has adopted standards for a unique health plan identifier (HPID) and other entity identifiers (OEID), for entities that are not health plans, health care providers, or individuals.

Supplier Numbers. Any organization that sells equipment or supplies that are billed to Medicare through Durable Medical Equipment Medicare Administrative Contractors (DME MACs) must be enrolled as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) through the National Supplier Clearinghouse (NSC). Suppliers of DMEPOS include but are not limited to pharmacies, oxygen suppliers, and outpatient physical therapy agencies.

Claims Processing by Medicare Contractors. Medicare contractors are required to accept claims from providers, physicians, and suppliers; process those claims; determine each beneficiary’s deductible status; pay the Medicare-approved amount to the provider, physician, supplier, or beneficiary, as the case may be; make prompt payment on clean claims within 30 days; and may make advance payments for Part B services in certain circumstances to avoid or reduce interest payments on claims that are not processed timely.

Medical Review of Claims. To fulfill the statutory mandate for proper payments, CMS has instituted a medical review program to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers. CMS contracts with Medicare administrative contractors, recovery audit contractors, program safeguard contractors, and zoned program integrity contractors to perform aspects of this medical review function.

Certification and Recertification of Medical Necessity

Introduction. Before payment can be made under the Medicare program for provider services, a physician normally must certify that the patient needed the services provided and, in some cases, recertify the continued need for those services. The content requirements and time factors relating to certifications and recertifications vary according to the items and/or services furnished and the facility or institution furnishing them.

Physician Certification and Recertification Rules. The Medicare program recognizes the physician as the key figure in determining utilization of health services. The physician decides on the necessity of a hospital admission; orders tests, drugs, and treatments; and determines the length of stay. In recognition of this, the Medicare Act calls for substantiation of certain physician decisions as an element of proper administration and fiscal control—referred to as “certification” and “recertification.”

Refunds, Underpayments and Overpayments

Introduction. There are many instances in which the Medicare program has paid too little (underpaid) or too much (overpaid). This section focuses on refunds, underpayments and overpayments to beneficiaries, providers, physicians, and suppliers; interest rates on overpayments and underpayments; and suspension of payments.

Refunds to Beneficiaries. A participating provider may not charge for items or services for which an individual is entitled to have payment made on his behalf. The provider must make adequate provision for return (or other disposition) of any payments incorrectly collected from an individual.

Interest on Overpayments and Underpayments. When a final determination is made that a provider (or a physician or supplier that has accepted assignment) has received an overpayment or underpayment from Medicare, and payment of the deficit is not made within 30 days of the determination, interest charges will be paid by the government on the balance due. The rate of
interest is established by the Secretary of Treasury. HHS publishes the rates in the Federal Register.

**Overpayments and Underpayments.** Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. An underpayment occurs whenever a beneficiary, provider, physician, or supplier is not paid the amount due under the Medicare program.

**Suspension, Offset, or Recoupment of Payments.** Medicare payments to providers and suppliers may be suspended, offset, or recouped by CMS or a Medicare administrative contractor (MAC) if CMS or the MAC possesses reliable information that an overpayment or fraud or willful misrepresentation exists or that the payments to be made may not be correct.

**Liability for Overpayments and Recovery Actions: Provider, Physician, and Supplier.** A provider (or physician or supplier) is liable for overpayments it received unless it is found to be “without fault.”

**Liability for Overpayments and Recovery Actions: Beneficiaries.** A Medicare payment made to a provider, physician, or supplier for services furnished a patient is considered to be a payment to the individual. Furthermore, when the provider, physician, or supplier is relieved of liability for an overpayment and it is attributable to the beneficiary, the overpayment may be recovered from the beneficiary or his survivors, including reduction of any Part B payment becoming due the individual or reduction of any Social Security or railroad retirement benefits due him, his estate, or his survivors.

**Collection of Past Due Loans: Scholarship Programs.** Individuals who have become delinquent in paying student loans owed to the U.S. government under certain programs must enter into an agreement with Medicare to provide services only on an assignment basis. In addition, deductions will be made from Medicare payments due them to reduce the amount of their outstanding loans.

**Waiver of Liability**

**Limitation of Liability for Disallowed Claims.** Whenever a Medicare claim is disallowed, the ultimate liability for payment for the services rendered falls upon the beneficiary. “Waiver of liability” provides financial relief to beneficiaries, providers, practitioners, and other suppliers for certain services and items that are not Medicare benefits.

**Limitations on Liability: Factors, Services, and Circumstances Triggering the Waiver.** The limitation on liability provisions are triggered by two factors:

(1) the provider, practitioner, physician, supplier or beneficiary must not have known or could not reasonably have been expected to know that items or services were not covered, and (2) the claims for items or services must have been denied because they were not reasonable and necessary, were not intermittent, did not constitute custodial care, or the patient was not homebound.

**Determining Beneficiary or Provider/Supplier Knowledge and Liability.** If it is clear and obvious that a beneficiary did know, before receiving a service or item, that Medicare payment for that service or item would be denied, the administrative presumption favorable to the beneficiary referred is rebutted and the beneficiary will be liable for payment. Providers, practitioners, and suppliers will have been expected to know that payment for services or items would be denied when services or items furnished do not meet locally acceptable standards of practice, when services or items are patently unnecessary, and when there is a finding of fraud or abuse in the provider, practitioner, or supplier’s billing practices.

**Appeals of Liability for Denied Claims.** A beneficiary may appeal a finding of liability for denied claims based on noncoverage. A provider, practitioner, or supplier that a Medicare Administrative contractor finds liable for all or a portion of charges for noncovered items and services furnished to a beneficiary also may appeal such a decision under certain conditions.

**Claims Appeals**

**Introduction.** The Social Security Administration and CMS make determinations with respect to beneficiaries, including entitlement, enrollment, coverage of benefits, status of coinsurance and deductibles. The agencies and contractors responsible for administering the Medicare program are required to provide notification to beneficiaries and providers of any determination made, any changes to the program and, when appropriate, beneficiary or provider appeal rights and the process for the specific
appeal. This explanation provides a summary of determinations and events that trigger notice and appeal rights.

Benefit and Other Notices. CMS and Medicare contractors must notify Medicare beneficiaries of actions taken on their behalf related to payment of claims and their appeal rights, and provide beneficiaries with information related to their benefits and a list of participating providers. Providers must notify beneficiaries of their right to privacy and, when appropriate, their patient rights. In addition, providers must provide beneficiaries with notice when services are to be terminated and give beneficiaries advance beneficiary notices when the providers believe that Medicare will not cover services.

Determination and Appeals

Entitlement Determinations and Appeals. The Social Security Administration (SSA) makes an initial determination on an individual’s application for Medicare benefits and entitlement to receive Medicare benefits. An individual who is dissatisfied with the initial determination may request a reconsideration if the requirements for obtaining a reconsideration are met. If the individual is dissatisfied with the reconsideration he or she may request a hearing before an HHS Administrative Law Judge (ALJ). If the individual is dissatisfied with the decision of the ALJ, he or she may request the Medicare Appeals Council (MAC) to review the case. Following the action of the MAC, the individual may be entitled to file suit in federal district court.

 Expedited Determination of Provider Service Terminations. A Medicare beneficiary is entitled to an expedited determination when the beneficiary receives a notice: (1) from a nonresidential provider (excluding a certification from a physician that the failure to continue services is likely to place the beneficiary’s health at significant risk) that the provider plans to terminate service, or (2) from a residential or hospice provider that it plans to discharge the beneficiary. If the beneficiary is not satisfied with the determination, he/she may request an expedited reconsideration.

Quality Improvement Organization Initial Denial Determinations. Quality improvement organizations (QIOs) have the authority to make determinations to ensure that care meets professionally recognized standards specifically related to reasonableness of service, medical necessity, and appropriateness of setting. QIOs also validate diagnosis related groups (DRGs) and may change diagnostic or procedural coding. Initial denial determinations by QIOs may be appealed and changes to DRGs may be re-reviewed or reopened.

Program Participation–Related Determinations and Appeals. CMS has the authority to make initial determinations on whether providers, suppliers, and practitioners meet applicable Medicare program requirements. Such initial determinations include whether a prospective provider or supplier qualifies to participate in the Medicare program and the effective date of a Medicare provider agreement or supplier approval. Providers are entitled to appeal such determinations.

Utilization Review Committee Determinations. The utilization review committee (URC), a staff committee of the institution or a group outside the institution, determines whether a further hospital or skilled nursing facility stay is medically necessary. The URC must consist of two or more practitioners to carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy; the other members may be other types of practitioners. Determinations of URCs are medical decisions and not a determination of the HHS Secretary. CMS, however, may consider such decisions when determining whether a beneficiary is entitled to Part A benefits.

Medicare Claims Appeals

Medicare Claims Initial Determinations. When a medical service provider or supplier submits a bill containing a request for payment for benefits, the contractor will make an initial determination approving, denying, or partially denying the claim. Actions that are, and are not, initial determinations are discussed in this explanation, as well as the reopening of initial determinations.

Overview of the Medicare Claims Appeal Process. The discussion provides an overview of the uniform process for Medicare Part A and Part B claims appeals, including the legislative and regulatory history, the major changes from the prior appeals process, and the four levels of administrative appeals under the uniform system.

Amount in Controversy Requirement. The amount in controversy is the dollar amount at issue that must remain to establish the right to a particular level of Medicare appeal. For redeterminations, reconsiderations, and qualified independent contractor hearings (QIC) for Medicare claims, there is no minimum dollar amount. There are, however, amount in controversy threshold amounts for administrative law judge (ALJ) hearing requests and judicial review that are adjusted annually.

Provider or Supplier Appeals Rights. Medicare providers and suppliers may file administrative appeals of initial determinations to the same extent as beneficiaries. Under the uniform appeals process, any person or entity with a right to appeal an initial determination is considered a party to the redetermination.
Appointment of Representative. A party may appoint any individual, including an attorney, to act as his or her representative in dealings with a Medicare administrative contractor or review entity at any point in the appeals process. Appointments are valid for one year and may be revoked. There are required elements for appointments. Representatives may charge fees for their services.

Redeterminations. If the provider, supplier, or beneficiary is dissatisfied with a Medicare contractor’s initial determination, the first step in the appeals process is a request for a redetermination of a denied claim. The contractor provides administrative appeal procedures employing contractor personnel not involved in the initial claim. Redeterminations may be requested without regard to the amount in controversy. Redetermination findings are binding on all parties unless a timely appeal is filed, the redetermination is revised, or the expedited appeals process is used.

Qualified Independent Contractor Reconsiderations. After an unsuccessful redetermination of a denied claim, a party may seek a reconsideration by a qualified independent contractor (QIC), the second level of administrative appeal. Reconsideration requests, evidence, timeframes, findings, and withdrawals are discussed, as well as medical necessity issues.

Administrative Law Judge Decisions. Providers, physicians, suppliers, and beneficiaries that are dissatisfied with a qualified independent contractor (QIC) reconsideration may appeal to an administrative law judge (ALJ) if the amount in controversy reaches the threshold amount. The ALJ hearing, which is the third level of the claims appeals process, results in a new decision by an independent reviewer. If parties are dissatisfied with results of the ALJ hearing, they are entitled to a hearing before the Medicare Appeals Council (MAC) of the Departmental Appeals Board (DAB).

Medicare Appeals Council Decisions. The fourth level of administrative review available to parties under the Medicare claims uniform appeals process, which follows the administrative law judge (ALJ) hearing decision or dismissal order, is a review by the Medicare Appeals Council (MAC), a ruling body within the Departmental Appeals Board (DAB) Medicare Operations Division. The MAC may affirm, reverse, or modify such decisions or dismissals. The MAC provides the final administrative review requested by beneficiaries, suppliers, or providers appealing ALJ decisions related to the denial of payment of claims.

Reopenings. A reopening is a remedial action taken by a Medicare administrative contractor, qualified independent contractor (QIC), administrative law judge (ALJ), or the Medicare Appeals Council (MAC) to change a binding determination or decision that resulted in either an overpayment or underpayment, even though the binding determination or decision may have been correct at the time it was made, based on the evidence of record. Reopenings are separate and distinct from the appeals process. There are specified timeframes for reopenings for Medicare administrative contractors, QICs, ALJs, and MACs as well as providers.

In general, providers, suppliers, or beneficiaries must exhaust administrative remedies before seeking a judicial resolution of their Medicare disputes.

Judicial Review

Court Review. In general, providers, suppliers, or beneficiaries must exhaust administrative remedies before seeking a judicial resolution of their Medicare disputes. The circumstances allowing for an appeal or escalation to federal district court are limited. If an appeal involves a state law or a constitutional question and the claim is separate and distinct from the Medicare claim, then certain procedural steps may be waived and the claim may be litigated in a separate action. The threshold issues litigated in these procedures are whether the federal claim (the case) “arises under the Medicare Act” and whether the Medicare claim is “inexplicably intertwined” with a federal constitutional or state law issue. Under the Medicare claims appeals process, court review is the fifth level of appeal.

Other Legal Processes. Courts usually review the Medicare program for the following reasons: claims appeals, cost report appeals, provider terminations, suspensions, exclusions and other sanctions for program abuses, but there are a number of other legal proceedings that decide aspects of the Medicare program. Examples of other legal proceedings that have implications for the Medicare program include: Administrative Procedure Act cases, bankruptcy proceedings, and disputes related to attorneys’ fees under the Equal Access to Justice Act. In addition, many Medicare-related cases highlight various legal
issues such as class certification, mootness, ripeness, standing to sue, sovereign immunity, rules of civil procedure, statute of limitation, subrogation, venue, and substantial evidence.

Section X.—Financing and Administration

Government Financing

Government Funding of the Medicare Program. The Hospital Insurance Trust Fund (HI), which covers Medicare Part A and the hospital insurance expenses for Medicare Part C, is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. The Supplemental Medical Insurance (SMI) Trust Fund, which covers Medicare Part B, Medicare Part D, and the medical insurance expenses for Medicare Part C, is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Income not currently needed to pay benefits and related expenses is held in the HI and SMI trust funds and invested in U.S. Treasury securities.

The Health Insurance Trust Funds. Medicare consists of four distinct parts: Part A, or Hospital Insurance (HI); Part B, or Supplementary Medical Insurance (SMI); Part C, or Medicare Advantage (MA); and Part D, the prescription drug benefit. There are separate trust funds in the U.S. Treasury for the HI and SMI parts of the Medicare program, namely, the “Federal Hospital Insurance Trust Fund” (covering Part A and some of Part C) and the “Federal Supplementary Medical Insurance Trust Fund” (covering Part B, Part D and some of Part C).

Administration of the Medicare Program

The Department of Health and Human Services. The Secretary of the Department of Health and Human Services (HHS) is responsible for implementing all laws that affect the Medicare and Medicaid programs as well as other federal programs that cover public health services. Agencies within HHS carry out the directions of the Secretary, through rulemaking, with respect to the programs delegated to them.

Health Care Reform Initiatives Under the Auspices of HHS. The Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) provides for a number of initiatives that aim to improve health care through modernized computer and data systems, research, education, patient-focus, and insurance market reforms.

Health Care Workforce Improvements. The Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) created programs to increase the quality of care patients receive by: improving the health care workforce, encouraging health care workers to serve as primary care providers, and improving access in areas that have underserved or unserved populations. In addition, several grant and loan repayment programs were established: to encourage physicians to work in primary care or pursue pediatric subspecialties, for nursing students, and for public health students or workers.

Health Care Professional Training Programs. The Patient Protection and Affordable Care Act created new programs to improve the education and training of the current and future health care workforce. The new law’s goals include improving health care workers’ education and training through loans and grants to encourage them to serve as primary care providers, and improving access in areas that have underserved or unserved populations.

Centers for Medicare and Medicaid Services. The Centers for Medicare and Medicaid Services (CMS) administers the Medicare program and, in partnership with state governments, the Medicaid and State Children’s Health Insurance Programs. CMS provides policy and guidance for the programs. The agency’s key responsibilities are: (1) Medicare health plans, (2) Medicare financial management and fee for service operations, (3) Medicaid and children’s health, and (4) survey and certification, and quality improvement.

Center for Medicare and Medicaid Innovation. The Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) created the Center for Medicare and Medicaid Innovation (CMI) within CMS. The goal of CMI is to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals by testing innovative payment and service delivery models.

Independent Medicare Advisory Board. The Independent Medicare Advisory Board, established by the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148), will make recommendations on reducing the per capita rate of growth in Medicare spending and improving access to health care. Report requirements, dates, and Congressional review are discussed.

Medicare Contractors

Introduction. Medicare claims processing contractors are now called Medicare Administrative Contractors (MACs) instead of carriers and fiscal intermediaries. In addition to contracting with MACs, CMS
also contracts with state health agencies and quality improvement organizations, as well as with a variety of entities under the Medicare Integrity Program, including recovery audit contractors and zoned program integrity contractors.

**Part A Medicare Administrative Contractors.** CMS was required to transfer the work of fiscal intermediaries and carriers to Medicare administrative contractors (MACs) by October 2011. Therefore, between October 2005 and October 2011, intermediaries were phased out and MACs began to administer Medicare Part A claims. The information below concerns the role of fiscal intermediaries prior to October 2011.

**Part B Medicare Administrative Contractors.** CMS was required to transfer the work of carriers and fiscal intermediaries to Medicare administrative contractors (MACs) by October 2011. Between October 2005 and October 2011, carriers were phased out and MACs began to administer Medicare Part B claims.

**MAC Competitive Bidding and Responsibilities.** Medicare administrative contractors (MAC) are fully operational in distinct, non-overlapping geographic jurisdictions, as of October 1, 2011. The HHS Secretary may renew a contract with a MAC without competitive bidding if the MAC has met or exceeded performance requirements; however, the Secretary must provide for competitive bidding at least every five years.

**State Health Agencies.** CMS contracts with state or local health agencies to determine whether providers of services meet conditions for participation in the Medicare program. If a provider or facility meets the required conditions, the state agency will certify this to the HHS Secretary.

**Quality Improvement Organizations**

**Introduction.** Quality improvement organizations (QIOs), usually non-profit organizations staffed by doctors trained in medical review, ensure that services provided to Medicare beneficiaries are medically necessary, reasonable, effective, and economical, and that services meet professionally accepted standards of quality. QIOs also ensure quality for Medicare Advantage health maintenance organization enrollees by addressing appropriateness of setting, under-utilization of services, accessibility to services, and potential for premature discharge. CMS enters into five-year contracts with QIOs.

**QIO Standards for Review and Review Responsibilities.** Under their contracts with CMS, QIOs are required to review the medical services provided to Medicare beneficiaries in settings such as acute care hospitals, specialty hospitals, and ambulatory surgical centers. QIOs also ensure that services (including both inpatient and outpatient) provided to beneficiaries in Medicare managed care plans meet accepted quality standards, including whether appropriate health care services have not been provided or have been provided in inappropriate settings.

**Quality improvement organizations (QIOs), ensure that services provided to Medicare beneficiaries are medically necessary, reasonable, effective, and economical.**

**The Scope of Work.** The duties and review functions required of quality improvement organizations (QIOs) are specified in a portion of their contracts known as the “Scope of Work” (SOW), which covers a three-year period. The first SOW covered the 1984-1986 contract period, and the current 10th SOW covers August 1, 2011 to July 31, 2014. QIO duties under SOWs have changed over the past 25 years; QIO SOWs now focus on quality improvement.

**Effect of QIO Determination on Payment of Claims.** A quality improvement organization’s initial denial determination is conclusive for payment purposes and is final and binding; however, it is appealable.

**QIO Hospital Reviews.** The responsibility for assuring timely medical review in hospitals and developing an effective system to accomplish the review rests with the quality improvement organization (QIO). Hospitals are required under the regulations to cooperate in the assumption and conduct of QIO review. QIOs’ review of hospitals include the review of admission notices to beneficiaries, the review of notices of noncoverage, investigation of antidumping violations, validation of DRG assignments, and investigation of circumvention of the prospective payment system.

**QIO Disclosure of Records.** Quality improvement organizations (QIOs) are responsible for maintaining complete and accurate records of all review activities in a manner that assures that all QIO medical record
review activities can be validated during auditing procedures, that there is documentation to verify accurate and complete performance of all required reviews, and that review activities and documentation are handled in a manner that ensures the confidentiality of all QIO data. To carry out their statutory responsibilities, QIOs are authorized to have access to Medicare beneficiaries’ and other patients’ medical records.

**QIO Sanction Recommendations for Providers.** The law and regulations establish three obligations of practitioners and providers that, if violated, can lead to the imposition of quality improvement organization (QIO) sanction recommendations. Services to Medicare patients must: (1) be furnished economically and be medically necessary, (2) meet professionally recognized standards of health care, and (3) be well-documented by evidence of medical necessity and quality of services. Sanction recommendations, types of sanctions, notices to providers, and administrative review are discussed.

**Denial Determinations and Appeals of QIO Initial Determinations.** Any beneficiary, recipient, or practitioner who is dissatisfied with a quality improvement organization (QIO) initial denial determination or change as a result of diagnosis related group (DRG) validation is entitled to notice and reconsideration of the determination/change by the QIO. An initial denial determination is a finding that health care services are unnecessary, unreasonable, or at an inappropriate level of care. A reconsideration may be requested for an initial denial determination.

**Quality Improvement Initiatives**

**Introduction.** Quality of patient care measures have been developed by CMS and by the Agency for Healthcare Research and Quality (AHRQ), and new quality measures have been mandated by the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148).

**CMS Quality Improvement Initiatives.** The Centers for Medicare and Medicaid Services (CMS) has developed a number of quality measures for Medicare and Medicaid patients, including: quality improvement organizations (QIOs); the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program for inpatient services; the similar Hospital Outpatient Quality Data Reporting Program for outpatient services; hospital value-based purchasing; Accountable Care Organizations; and sanctions for hospital-acquired conditions. The agency also plans to implement a value-based purchasing program for skilled nursing facilities.

**AHRQ Clinical Guidelines and Quality Measures.** The mission of the Agency for Healthcare Research and Quality (AHRQ) is to enhance the quality, appropriateness and effectiveness of health care services for all Americans, not just those whose care is being reimbursed by the Medicare or Medicaid program, by developing clinical practice guidelines and associated quality measures, and by disseminating research findings. AHRQ is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. The Patient Protection and Affordable Health Care Act (PPACA) (P.L. 111-148) included AHRQ in it provisions related to the development and implementation of quality of care improvement.

**National Strategy for Improvement of Americans’ Health.** A national strategy for quality of care improvement for all patients is now mandated by the health care reform legislation of 2010, the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148), which requires the HHS Secretary to define a national strategy for health care quality improvement, after collaborating with state Medicaid agencies and after receiving the ideas of a consensus entity such as the National Quality Forum, composed of multi-stakeholder groups. The strategy will guide HHS, which will be advised by CMS and by the Agency for Healthcare Research and Quality (AHRQ), as it identifies gaps where no quality measures exist or where quality measures need improvement, consistent with the national strategy. The improved quality measures will be available for use in all federal health programs as well as in all health care systems.

**Experiments and Demonstrations**

**Introduction.** The HHS Secretary may undertake studies, conduct experiments, and establish ongoing demonstration projects relating to Medicare to determine whether, through additional incentives, changes in the methods of payment or reimbursement would increase the efficiency and economy of health services without adversely affecting quality of the services.

**Demonstration Projects Authorized by PPACA.** The Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) added numerous Social Security Act sections that authorize or require the Secretary to undertake demonstration programs relating to Medicare. These programs aim to reduce expenditures and improve health outcomes.
Private Health Insurance Plans

Overview. Under Medicare law, states may not be precluded from providing, and individuals may not be precluded from purchasing or otherwise securing, protection against health costs. Medicare law, however, excludes payment on a primary insurer basis to the extent that coverage is provided by another insurer. Accordingly, most private insurance companies have modified their policies for the aged to make them supplementary to the benefits payable under Medicare.

Health Care Prepayment Plans. Health care prepayment plans (HCPPs) are public or private entities organized under the laws of a state to provide health services on a prepayment basis to enrolled members. These plans are not health maintenance organizations (HMOs) or competitive medical plans (CMPs) because, unlike HMOs and CMPs, they only partially cover Medicare benefits. HCPPs are eligible to enter into agreements with the HHS Secretary to furnish services to Medicare beneficiaries and are paid for their reasonable costs in providing Medicare-covered services to Medicare enrollees.

“Medigap” Insurance. Approximately 75 percent of all Medicare beneficiaries choose to purchase private “Medigap” insurance to help pay Medicare deductibles and coinsurance or services and items not covered by Medicare. The term “Medigap” covers employer-sponsored health plans, limited benefit plans such as indemnity policies for specified disease coverage, and long-term care policies.

ERISA Issues. The Employee Retirement Income Security Act of 1974 (ERISA) is a federal statute that regulates private employer group health plans. In certain circumstances, ERISA plans may be required to help pay premiums for eligible employees or pay uncompensated or under-compensated medical expenses that were covered under the Medicare or Medicaid program.

Section XI.—Provider Agreements and Conditions of Participation

Provider Agreements

Enrollment of Providers and Suppliers in Medicare. Health care providers and suppliers need to enroll with Medicare to be reimbursed for the providing of services to beneficiaries on a regular basis. Medicare distinguishes between providers and suppliers of health care and has slightly different procedures for the enrollment of each. Providers are generally institutions like hospitals, skilled nursing facilities, and home health agencies amongst others. Suppliers are generally health care practitioners like physicians and physical therapist, but also include companies that supply medical equipment and supplies. So laboratories and mammography screening centers are also suppliers.

Standards for Electronic Enrollment of Providers. The Secretary of HHS, in consultation with the Health Information Technology (HIT) Policy Committee and the HIT Standards Committee of the Office of the National Coordinator for HIT, is required to develop standards to facilitate electronic enrollment of providers in federal and state health and human services programs.

Definition of “Provider” and “Supplier.” “Provider” means: (1) a hospital, a critical access hospital (CAH), a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has an agreement in effect to participate in Medicare; or (2) a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement to furnish only outpatient physical therapy; or speech pathology services, or (3) a community mental health center that has a similar agreement in effect to furnish only partial hospitalization services.

In contrast, “supplier” means a physician, other practitioner, or an entity other than a provider that furnishes health care services under Medicare. This distinction is important because both providers and suppliers must enroll in the Medicare program to be considered participating providers, but certain provisions of the law on provider agreements apply only to providers.

Provider Agreements and Supplier Participating Provider Agreements. A provider agreement is an agreement between CMS and a provider of services to provide services to Medicare beneficiaries and comply with the rules regarding provider participation. The terms of the written agreement are stated in broad terms to encompass compliance with the provisions of §1866 of the Social Security Act, applicable provisions in Title 42 of the Code of Federal Regulations, Title VI of the Civil Rights Act of 1964, and §504 of the Rehabilitation Act of 1973.

Enrollment of DMEPOS Suppliers. A separate enrollment process has been established for suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). To enroll, DMEPOS suppliers apply to the National Supplier Clearinghouse (NSC) instead of a Medicare contractor. In addition, DMEPOS suppliers must obtain and submit a surety bond and must revalidate their enrollment every three years instead of the five years for all other providers and suppliers.
Allowable Charges to Beneficiaries. The provider agreement requires a provider of services to limit its charges to beneficiaries to the costs of noncovered services and to the deductible, coinsurance, and copayment charges allowed under federal regulations.

Prepayment from Beneficiary. A provider agreement contains assurances that a provider will not (1) require an individual entitled to hospital insurance benefits to prepay for inpatient services as a condition of admittance; (2) deny covered inpatient services to an eligible individual for failure to pay a requested amount at or before admission; (3) evict, or threaten to evict, an individual for inability to pay a deductible or a coinsurance amount required under Medicare; or (4) charge a patient for an agreement to admit or readmit the individual on some specified future date or for failure to remain an inpatient for a certain period of time or for failure to give advance notice of departure.

Arrangements with Other Providers. Services may be furnished to a beneficiary by an organization or supplier “under arrangements” with a provider of services. In this situation, the provider makes the claim for Medicare payment.

Change in Provider Ownership. To provide continuity of coverage for beneficiaries when there is a change of ownership, a Medicaid state agency must automatically assign the Medicare agreement to the new owner, subject to all the terms and conditions under which the original agreement was issued.

Termination of Provider Participation. A provider may voluntarily terminate its participation in the Medicare program or its participation may be terminated by the Secretary of the Department of Health and Human Services for cause.

Provider Agreement Forms. When an entity requests provider status in either the Medicare or Medicaid program, the state licensing agency sends a certification packet, which includes all the forms needed for the application process. The applicant should return a signed provider agreement to the Regional Office as soon as possible even though the agreement cannot be effective until an onsite survey is completed.

Conditions of Participation

Introduction. When an entity requests provider status in either the Medicare or Medicaid program, the state licensing agency sends a certification packet, which includes all the forms needed for the application process. The applicant should return a signed provider agreement to the Regional Office as soon as possible even though the agreement cannot be effective until an onsite survey is completed.

Survey of Providers and Suppliers for Conformance to Conditions of Participation. As a general rule, Medicare will only pay for services rendered in facilities that meet Medicare conditions of participation or conditions for coverage. The determination as to whether a facility meets Medicare requirements is made by the Secretary of HHS.

Hospital

Definition of “Hospital.” The Medicare statutes establish a number of specific requirements to be met by participating hospitals (including small rural hospitals, swing-bed hospitals, and psychiatric hospitals). The term “hospital” does not include, unless the context otherwise requires, a critical access hospital (CAH).

EMTALA Prohibition on Patient Dumping. If an individual “comes to the emergency department,” of a hospital, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists. The examination must be conducted by qualified medical or nursing personnel. If an emergency medical condition is determined to exist, the hospital must provide any necessary stabilizing treatment or an appropriate transfer. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under Emergency Medical Treatment and Active Labor Act (EMTALA) ends.

Investigation of EMTALA Violations. A hospital must report to CMS or the state agency any time it believes it has received an individual who has been transferred from another hospital in violation of the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. If a hospital fails to meet these requirements, CMS may terminate the provider agreement. The Office of Inspector General (OIG) has the responsibility and authority to assess civil monetary penalties (CMPs) or exclude physicians from the Medicare program when a hospital or physician violates these requirements.

Requirements for Hospital Participation. Only a hospital that meets all of the statutory requirements and that is found to be in compliance with each of the applicable additional conditions prescribed in the regulations may agree to participate in the program.

Critical Access Hospitals

Definition of “Critical Access Hospital.” Critical access hospitals (CAHs) are rural community hospitals that must provide 24-hour emergency services, but can only operate a limited number of inpatient beds in which the...
patients’ average length of stay (ALOS) also is limited. CAHs tend to have a low average daily census and to be the most Medicare-dependent facilities. Becoming a CAH is a process that requires a hospital to meet criteria that have been developed both by the state in which the facility is located through its Office of Rural Health, and the federal government through CMS.

**Requirements for CAH Participation.** CMS will certify facilities that meet the definition based on their compliance with the Medicare conditions of participation (CoPs) for critical access hospitals (CAHs) in 42 C.F.R. §485 Part F.

**Psychiatric Hospital and Unit Requirements.** The requirements for Medicare conditions of participation and coverage of services in psychiatric hospitals and psychiatric hospital units, including special staffing, medical records, physician certification and treatment plan requirements are described in detail in 42 C.F.R. §412, 42 C.F.R. §424, and 42 C.F.R. §428 and in Chapter 2 of the Medicare Benefit Policy Manual.

**Quality Improvement Organization (QIO) Review.** All psychiatric facilities must have agreements with quality improvement organizations (QIOs) to review services and items provided to Medicare beneficiaries by hospital staff, physicians, and other health care practitioners. The QIO reviews the validity of diagnostic information provided by the facility, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided with respect to services for which payment may be made under Part A of Medicare. This basic requirement will not be changed by the imposition of the inpatient psychiatric facility prospective payment system.

**Skilled Nursing Facilities**

**Definition of “Skilled Nursing Facility.”** The law defines “skilled nursing facility” as an institution or a distinct part of an institution that has in effect a transfer agreement with one or more participating hospitals and that: (1) is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of the injured, disabled, or sick residents; and (2) meets detailed requirements relating to services provided, residents’ rights, professional standards, health and safety standards, and notification to the state of changes in ownership or control.

**Requirements for SNF Participation.** The statutory requirements for Medicare participating skilled nursing facilities (SNF) as well as state nursing facilities participating in the Medicaid program are incorporated in the conditions of participation stated in 42 C.F.R. 483 Part B. For Medicare participation, a SNF must also sign a participation agreement and must be in compliance with the provisions of federal laws that prohibit discrimination and protect other civil rights.

Medicare will only pay for services rendered in facilities that meet Medicare conditions of participation or conditions for coverage.

**Transfer Agreements Between Skilled Nursing Facilities and Hospitals.** A hospital and a skilled nursing facility are considered to have a transfer agreement if there is a written agreement between them (or a written undertaking by the person or body controlling them, in the case of institutions under common control) that provides reasonable assurance that (1) there will be timely transfer of patients between the institutions whenever it is determined medically appropriate by the attending physician, (2) there will be timely transfer between the institutions of medical and other information needed for patients’ care or for determining whether patients can be cared for adequately in some other way.

**Home Health Agencies**

**Definition of “Home Health Agency.”** The Social Security Act specifies a number of requirements that must be met by participating home health agencies and authorizes the Secretary of Health and Human Services to prescribe other requirements considered necessary in the interest of health and safety of beneficiaries. In addition, a home health agency must sign a participation agreement and must be found to be in compliance with the provisions of Title VI of the Civil Rights Act of 1964.

**Requirements for HHA Participation.** Medicare law specifies the conditions that a home health agency (HHA) must meet to participate in Medicare, including (1) submitting claims for Medicare home health services on the basis of the geographic location where the service is furnished, and (2) disclosing the names and addresses of individuals with ownership or control interest, as well as officers and managers.

**Home Health Agency Administration.** The regulations specify the standards for protection of patient
rights, organization, service and administration of the home health agency, review of policies by professional personnel, acceptance of patients, plans of care, medical supervision, and reporting of patient assessment data.

Required HHA Services. The regulations specify the services that an HHS must provide for patients in these areas: skilled nursing, therapy, social, home health aides, clinical records, program evaluation, and assessment.

Comprehensive Outpatient Rehabilitation Facilities

Definition of “Comprehensive Outpatient Rehabilitation Facility.” A comprehensive outpatient rehabilitation facility (CORF) is a nonresidential public or private facility that provides physicians’ services, physical therapy, and social or psychological services.

Requirements for CORF Participation. The conditions that comprehensive outpatient rehabilitation facilities (CORFs) must meet to participate in Medicare are described in 42 C.F.R. Part 485 Subpart B.

Hospice Programs

Definition of “Hospice.” A “hospice” is a public agency or private organization that is primarily engaged in providing care to the terminally ill. To receive Medicare reimbursement it must have a valid provider agreement and meet the conditions of participation specified in the law and in the regulations. A hospice may be dually certified as a hospice and as part of a hospital, skilled nursing facility, home health agency, or intermediate care facility; however, it must have a separate provider agreement, file separate cost reports, and independently meet the hospice conditions of participation.

Requirements for Hospice Participation. The regulations implementing the Medicare hospice conditions of participation define the services hospices must provide as needed or on a 24-hour basis, the qualifications of hospice personnel, and the administration requirements of the hospice.

Providers of Outpatient Therapy Services

Definitions Related to Outpatient Therapy Services. To participate in the Medicare program as a provider of outpatient physical therapy and/or speech pathology services, a rehabilitation agency, clinic, or public health agency is required to meet standards specified in the Social Security Act and regulations promulgated by the Secretary of HHS in the interest of the health and safety of patients.

Requirements for Participation for Providers of Outpatient Therapy. The requirements in the statute and the additional health and safety requirements prescribed by the Secretary have been incorporated into conditions of participation for rehabilitation agencies, clinics, and public health agencies as providers of outpatient physical therapy and/or speech pathology services.

Laboratories

Definition of “Laboratory.” A “laboratory” is a facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of human health, or for the assessment of human health. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only functioning as a mailing service and not performing testing are not considered laboratories.

Independent Diagnostic Testing Facilities. Independent diagnostic testing facilities (IDTF) perform diagnostic tests that do not involve examination of human specimens. An IDTF may be a fixed location, a mobile entity, or the office of an individual physician or nonphysician practitioner if authorized by state law.

Requirements for Laboratories. CMS is responsible for the administration of the Clinical Laboratories Improvement Act of 1967. CMS and the Public Health Service (PHS) share joint responsibility for the development of the federal requirements for laboratories. Within the PHS, the Centers for Disease Control (CDC) and the Food and Drug Administration (FDA) provide technical and scientific expertise in the establishment of regulations. Responsibility for determining the complexity of in vitro devices, including products used for testing, rests with the FDA.

Laboratory Application Requirements and Fees. Laboratories that seek certification to perform tests to either moderate or high complexity must apply and pay a fee for a registration certificate.

Types of Laboratory Certificates. The title of the certificate issued to a laboratory that tests human specimens for diagnostic or treatment purposes depends partly upon the entity that certifies the lab’s compliance with Clinical Laboratory Improvement Amendments (CLIA) requirements. When HHS or CMS certifies compliance, the lab receives a certificate of compliance. When an accreditation organization has made the determination,
CMS will issue a certificate of accreditation. Labs that are determined exempt because of their certification by state programs do not receive a certificate from HHS; however, they are required to admit inspectors for HHS’ validation surveys to confirm that the state program continues to meet requirements.

**Appeal Procedures for Denial, Revocation, Suspension or Limitation of a Laboratory Certificate.** A laboratory may appeal any action by HHS to suspend, revoke, or limit a laboratory’s certificate or accreditation for noncompliance with Clinical Laboratory Improvement Amendment (CLIA) requirements.

**Laboratory Proficiency Testing.** Proficiency testing is the testing of laboratory samples to assess the accuracy of the laboratory's results. Clinical Laboratory Improvement Amendments (CLIA) require quarterly testing unless the Secretary determines that less frequent testing is sufficient; there may be no fewer than two testing events per year.

**Quality Control, Quality Assurance, and Inspections.** The laboratory must establish and follow written quality control procedures for each test method to assure the accuracy and reliability of patient test results and reports. The laboratory must meet the standards relating to general laboratory systems, each phase of the testing process, particular specialties and sub-specialties, and for test methods, equipment, supplies, and materials. A written procedure manual for the performance of all tests must be readily available and followed by laboratory personnel.

**Laboratory Personnel Requirements.** The regulations provide separate personnel requirements for laboratories conducting moderate complexity testing and those conducting high complexity testing.

**Sanctions and Enforcement Procedures.** The law requires the Secretary to develop and implement a range of sanctions for laboratories found to be out of compliance with the conditions for Medicare coverage of clinical diagnostic tests on human specimens.

**Portable X-Ray Service Suppliers**

**Definition of “Portable X-Ray Services.”** The requirements for diagnostic x-ray services provided in a patient’s home by suppliers using portable x-ray equipment address: (1) orders for the service; (2) condition of the equipment; (3) location where the services are furnished; and (4) the qualifications of the individuals furnishing the service.

**Requirements for Portable X-Ray Service Suppliers.** Suppliers of portable x-ray services must be in compliance with conditions for coverage relating to the orders for services, the condition and maintenance of the equipment, qualifications of the personnel performing and responsible for the services and patient safety.

**Organ Procurement Organizations**

**Definition of “Organ Procurement Organization.”** The law allows payment under Medicare and Medicaid for organ procurement costs incurred by transplant hospitals or centers only if such costs are paid to an organ procurement organization that meets Medicare requirements.

**Requirements for Organ Procurement Organizations.** To qualify as an “organ procurement organization” (OPO) for Medicare and Medicaid purposes, an organization must apply to CMS using the appropriate form and meet regulatory requirements.

**End-Stage Renal Disease Facilities**

**Definition of “ESRD Facility.”** A “dialysis facility” means an entity that provides outpatient maintenance dialysis services or home dialysis training and support services, or both. A dialysis facility may be an independent or hospital-based unit that includes a self-care dialysis unit that furnishes only self-dialysis services.

**Requirements for ESRD Facilities.** In 2008, CMS made substantial revisions to the conditions for coverage of end-stage renal disease (ESRD) services and codified most of the regulations at a new Part 494. The amendments strengthened requirements in the areas of patient safety, patient rights, and quality of care.

**Rural Health Centers and FQHCs**

**Definition of “Rural Health Clinic.”** A rural health clinic is a facility primarily engaged in furnishing to outpatients “rural health clinic services” in an area that is not an urbanized area and employs a physician assistant or nurse practitioner, among other requirements.

In the case of a facility that is not a physician-directed clinic, the clinic must have an arrangement with one or more physicians so that a physician is responsible for the periodic review of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance of physician assistants and nurse practitioners, the preparation of medical orders for care and treatment of clinic patients, and the physician availability for referral and consultation, and for advice and assistance in the management of medical emergencies.
**Definition of “Federally Qualified Health Center.”**
Federally Qualified Health Centers (FQHCs) are like rural health clinics (RHCs), but are usually in urban areas.

**Requirements for Rural Health Clinics and Federally Qualified Health Centers.** The conditions that rural health clinics and Federal Qualified Health Centers (FQHCs) must meet to qualify for reimbursement under Medicare and Medicaid are contained in Subpart A of 42 C.F.R. §491.

**Ambulatory Surgical Centers**

**Definition of “Ambulatory Surgical Center.”** An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.

**Requirements for Ambulatory Surgical Centers.** An ambulatory surgical center (ASC) must have an agreement with CMS to participate as an ASC and meet the conditions for coverage. Although it is considered a “supplier” under the law, an ASC must be certified and approved to enter into a written agreement with CMS.

**Mammography Facilities**

**Definition of “Mammography Facilities.”** Mammography facilities are regulated by the Food and Drug Administration and are considered Medicare suppliers of “mammography services,” including screening mammography and diagnostic mammography services.

**Requirements for Suppliers of Mammography Services.** Mammography services must be ordered by a doctor of medicine or osteopathy and furnished by a supplier of diagnostic mammography services that meets the certification requirements of the Public Health Service Act.

**Section XII.—Program Integrity and Fraud and Abuse**

**Program Integrity**

**Introduction.** The federal government consistently has increased its oversight, regulation, and enforcement authority over the health care industry by creating programs such as the Medicare and Medicaid Integrity Programs, required more transparency through ownership and financial disclosures and affiliations, and intensified its screening and enrollment process for participation in Medicare and Medicaid.

**Medicare Integrity Program Overview.** The primary goal of the Medicare Integrity Program (MIP), which was established in 1996, is the accurate payment of claims. The Center for Program Integrity (CPI) is the CMS component responsible for oversight of all of CMS’ program integrity efforts. In collaboration with other CMS Centers, Offices, and the Chief Operating Officer, CPI develops and implements a comprehensive strategic plan, objectives and measures to carry out CMS’ Medicare, Medicaid, and CHIP program integrity mission and goals and ensure program vulnerabilities are identified and resolved.

**Eligible Entities.** To qualify for a contract under the Medicare Integrity Program (MIP), an eligible entity must meet certain requirements, one of which is to demonstrate that the entity’s financial holdings, interests, or relationships will not interfere with its ability to perform as required. Once an entity is deemed eligible, the entity must comply with contracting procedures established by the HHS Secretary.

**Medicare Integrity Program Contractors.** Medicare administrator contractors (MACs), Comprehensive Error Rate Testing (CERT) contractors, Medicare secondary payer (MSP) contractors, recovery audit contractors (RACs), National Supplier Clearinghouse (NSC), and zone program integrity contractors (ZPICs) ensure that CMS pays the correct amount for covered and accurately coded services rendered to eligible beneficiaries by legitimate providers.

**Medicare Integrity Program Activities.** Medicare contractors conduct a variety of activities under the Medicare Integrity Program (MIP), including: (1) reviewing for potential fraud related to activities of Medicare providers; (2) utilization review; (3) auditing cost report payments for Medicare providers to ensure proper payment; (4) determining whether a payment is proper under Medicare when Medicare is a secondary payor and recovering any improper payments; (5) overpayment recovery; (6) educating providers, suppliers, beneficiaries, and other persons regarding payment integrity and benefit quality assurance issues; and (7) developing and periodically updating a list of items of durable medical equipment (DME).

**Rewards for Reporting Suspected Cases of Fraud and Abuse.** The Incentive Reward Program (IRP) was established to pay an incentive reward to individuals who provide information on Medicare fraud and abuse or other sanctionable activities. Payment is based on, among other things, the significance of the reported information and the amount of recovery.
**Provider Application, Screening, and Enrollment.** Provider application, screening, and enrollment rules have been enhanced to prevent the enrollment of providers and suppliers that pose a risk to the integrity of the Medicare program. In particular, the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) and the Health Care and Education Reconciliation Act (HCERA) (P.L. 111-152) made significant changes to Medicare, Medicaid and the Children’s Health Insurance Program (CHIP) to reduce fraud, waste, and abuse at the provider enrollment level of program participation.

**Disclosure of Ownership Information.** The HHS Secretary requires certain entities to disclose their ownership information as a condition of: (1) the entity’s participation in or certification under Medicare, or (2) the approval or renewal of a Medicare contract between the entity and the HHS Secretary. These entities are referred to as “disclosing entities.”

**Access to Books, Documents, and Records of Subcontractor.** Under certain provider contracts, Medicare providers are required to provide access to the HHS Secretary, the Comptroller General, and their duly authorized representatives to certain contracts for services and to books, documents, and records necessary to verify the costs of the services. The contracts affected include: (1) contracts between providers and their subcontractors, and (2) contracts between the subcontractors and organizations related to the subcontractor by control or common ownership.

**Fraud and Abuse**

**Introduction.** State and federal government agencies use a number of statutes and regulations to combat health care fraud and abuse by individuals and health care providers. Criminal penalties are authorized by federal law for acts involving federal health care programs such as schemes to defraud a federal health care benefit program or to obtain money or property owned by a federal health care benefit program by fraudulent or false means. Violators of health care fraud and abuse laws or related regulations may be faced with substantial civil monetary penalties for each abuse, temporary or permanent program exclusion, or federal imprisonment.

**Authority and Role of the Office of Inspector General.** The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) is charged with investigating suspected fraud or abuse and performing audits, inspections, and special studies of department programs. The OIG exercises an oversight role to assure that CMS is prudently and efficiently managing the Medicare program through evaluation of CMS self-assessment techniques and by conducting independent reviews of CMS activities. In addition, the OIG acts on behalf of the Secretary when carrying out activities under the Health Care Fraud and Abuse Control Program.

**Health Care Fraud and Abuse Control Program.** The Health Care Fraud and Abuse Control Program (HCFAC) coordinates federal, state and local law enforcement activities to combat fraud and abuse within federal health care programs. The program is administered under the joint direction of the U.S. Attorney General and the Secretary of the Department of Health and Human Services (HHS), acting through the HHS Office of Inspector General (OIG).

**The Federal Criminal Statutes.** There are a wide variety of federal criminal statutes available to charge and prosecute individuals in health care fraud cases under Title 18 of the United States Code, especially in the administration of the Medicare and Medicaid programs. Most of the statutes are applicable to most white collar offenses, including those that arise in the health care context. Some federal criminal statutes apply solely to health care-related misconduct.

**The Federal False Claims Act and Qui Tam Actions.** The federal False Claims Act (FCA) authorizes federal prosecutors to file a civil action against any person or entity that knowingly files a false claim with a federal health care program, including Medicare or Medicaid. A party that commits any prohibited acts under the FCA may be subject to civil penalties, damages, criminal prosecution, and/or exclusion from participation in federal and state health care programs. The FCA’s *qui tam* provisions empower private persons to bring a civil action for
Criminal Penalties for Acts Involving Federal Health Care Programs. Soc. Sec. Act §1128B, “Criminal Penalties for Acts Involving Federal Health Care Programs,” targets health care payment practices and business arrangements by prohibiting fraudulent billing activities under all federal health care programs. The law imposes civil monetary and criminal penalties for fraudulent billing activities to all federal health care programs that are funded in part by the federal government with the exception of the Federal Employee Health Benefit Program.

Anti-kickback Statute. Soc. Sec. Act §1128B(b)—often referred to as the Anti-Kickback Statute—prohibits payments to induce referrals, including kickbacks, bribes, or rebates.

Prohibition Against Certain Physician Ownership and Referral (Stark Law). Soc. Sec. Act §1877 prohibits a physician from making a referral to an entity for the furnishing of clinical laboratory services and other designated health services, for which Medicare would pay, if the physician (or a member of the physician’s immediate family) has a “financial relationship” (ownership or compensation) with that entity. Soc. Sec. Act §1877(a)(1)(B) further prohibits an entity from presenting or causing to be presented a Medicare claim or bill to any individual, third-party payor, or other entity, for services furnished under a prohibited referral.

Exceptions to the Physician Self-Referral Prohibition (Stark Law). The general physician self-referral prohibition (Stark Law) is subject to numerous exceptions, some of which are set out in the statute and others of which have been adopted by CMS. If a financial arrangement implicates the Stark Law, then it must satisfy all of the requirements of an exception to comply with the law. The three categories of exceptions are (1) either ownership/investment or compensation; (2) only ownership or investment interests; or (3) only compensation arrangements.

Civil Money Penalties and Assessments. The Secretary of HHS is authorized to impose administrative sanctions in the form of civil money penalties (CMPs) and assessments against any person, organization, agency, or public or private entity that makes or causes the making of false or improper claims and requests for payment from Medicare, Medicaid or other federally sponsored health related programs. Violators may be fined up to $10,000 as a penalty for each item or service fraudulently claimed and, in addition to this penalty, assessed up to three times the amount claimed for each item or service.

Exclusion for Program-Related Abuses. The Secretary of the Department of Health and Human Services (HHS) must exclude individuals and entities from program participation for convictions related to the delivery of health care items or services, patient abuse, or controlled substances. The Secretary may exclude individuals and entities on other grounds, including convictions relating to controlled substance abuse and supply, or for engaging in other activities that would lead to the imposition of criminal and civil penalties under the Social Security Act.

Antitrust Limitations on Health Care Providers. Both the Antitrust Division of the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) have initiated actions through their advisory opinion process that have led to settlements and sanctions against health care providers. While the majority of these actions involve antitrust limitation, DOJ also has used its advisory process to issue complaints in suspected cases of violations of the federal False Claims Act and the prohibition against physician self-referral.

Section XIII.—Cost Reports

Allowable Costs

Introduction. “Allowable costs” are costs that the Medicare program will reimburse or accept on a provider cost report. Regulations and provider manual guidelines describe in detail which costs comply with the statutory requirement that Medicare should not pay for costs that are unnecessary in the efficient delivery of needed health services for Medicare beneficiaries.

Capital-Related Costs. Capital-related costs include depreciation, interest expense, lease expense, property taxes, building costs, and return on equity capital of proprietary providers. For hospitals under a prospective payment system, capital costs are fully incorporated into the prospective rates. A change in ownership will affect the cost bases for interest, depreciation, and return on equity capital for hospitals and skilled nursing facilities.

Operating Costs. Operating costs are the expenses of operating the business. Bad debts, charity, and courtesy allowances are not Medicare allowable costs, except for deductible and coinsurance amounts not paid by Medicare beneficiaries. The net cost of approved educational activities constitute an allowable cost. Research costs may not be included in allowable costs unless they are related to the care of a specific patient.
Allowable Depreciation. Providers are allowed to claim reimbursement for depreciation on assets used to provide covered services to beneficiaries. Depreciable assets include buildings, building equipment, movable equipment, land improvements, and leasehold improvements. Careful records of each asset must be kept in order to support any depreciation allowances claimed.

Revaluation of Assets in Cases Involving Acquisition of Stock. No revaluation of assets may occur if a transaction involves the acquisition of capital stock only. In transactions involving a statutory merger (in which one of the existing corporations survives) or consolidation (in which a new corporate entity is created), the assets of the acquired or merged provider(s) may be revalued only if the transaction is between unrelated parties.

Allowable Interest. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

Medicare Reimbursement of Bad Debts. Medicare reimburses providers on the prospective payment system for 70 percent of the allowable bad debt attributable to unpaid cost sharing, i.e., deductibles or copayments, owed by Medicare beneficiaries. The provider must establish that the debt is uncollectible, meaning that there is no reasonable prospect of payment. Usually, the provider must have made reasonable efforts to collect the amounts owed.

Reasonable Collection Effort. Sec. 4008 of the Omnibus Budget Reconciliation Act (OBRA) of 1987 (PubL No 100-203) prohibited any changes in the Medicare policy in effect on August 1, 1987, with respect to Medicare payments to providers for reasonable costs relating to unrecovered costs associated with bad debts, including the criteria for what constitutes a reasonable collection effort. Sec. 6023 of OBRA 1989 (PubL No 101-239) amended Sec. 4008 by adding this statement: “The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigence determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital’s collection policy.”

Hill-Burton Free Care Costs. One of the most controversial issues to arise regarding Medicare reimbursement was whether providers should be reimbursed for the cost of the free care supplied to indigent patients mandated by the Hill-Burton construction subsidization program. Under the Hill-Burton Act, passed in 1946, health care institutions are required to “furnish needed services for persons unable to pay therefor” in exchange for grants, loan guarantees, and interest subsidies for hospital construction and modernization. [42 U.S.C. §291c(e).]

Cost of Education Activities. The net cost of educational activities—formally organized or planned programs of study operated or supported by a provider and approved in accordance with requirements—is an allowable Medicare cost.

Statutory and Regulatory Provisions on Payment for Education Costs. Medicare uses a complicated formula to pay each hospital for direct graduate medical education (GME) costs in approved training programs. The payment rules regarding the direct costs of GME are at Soc. Sec. Act §1886(h).

Redistribution of Costs. Medicare will reimburse for direct costs in certain approved educational activities but Medicare will not reimburse for activities that are customarily supported by the community or the redistribution of costs from educational institutions or units to patient care institutions.

Joint Educational Activities. Joint educational programs substantially reduce hospital costs for training nurses as compared to the costs incurred by providers in operating their own programs. Reasonable cost reimbursement of the clinical training costs associated with nursing and allied health education programs not operated by a hospital upon certain condition are allowable costs.

Additional Payments for Educational Programs Associated with Medicare Advantage Enrollees. Additional payments are provided to hospitals for nursing and allied health education programs associated with services to Medicare Advantage enrollees.

Research Costs. Research costs that are related to “usual patient care” are Medicare allowable costs. “Usual patient care” means items and services ordinarily used to treat patients that are provided under the supervision of a physician. The costs of “usual patient care” will be reimbursable to the extent that they are not met by research funds.

Offset of Grants, Gifts and Income from Endowments. Grants, gifts, and income from endowments that are not restricted as to their use by the donor will not be deducted from operating costs in computing reimbursable costs. On the other hand, grants, gifts, and income from endowments that are designated by the donor to be used for a specific operating cost must be deducted from that cost or group of costs for cost reporting periods beginning before October 1, 1983.

Value of Services of Nonpaid Workers. The value of services performed by nonpaid workers may be added to operating expenses in determining allowable costs for the Medicare cost report, subject to a number of qualifications.
Purchase Discounts and Allowances. Providers are expected to reduce their costs by taking advantage of the various discounts available to them, such as purchase discounts, allowances, and refunds, to reduce the cost of goods or services purchased thereby reducing allowable costs. If a Medicare administrative contractor’s audit finds the provider failed to take advantage of such discounts, the provider’s cost report will be adjusted as necessary to reduce the excessive costs.

Compensation of Owners. Services performed by owners of providers will be given a reasonable allowance of compensation and will be considered allowable costs, as long as the services performed are a necessary function of the provider’s operation. The reasonable allowance for the services of sole proprietors and partners will constitute the reasonable value of the services rendered. For corporations, the test of what is considered reasonable applies to the actual compensation of all individuals performing services for the provider.

Cost to Related Organizations. An organization related to a provider as a result of common ownership or control is treated as if it were part of the provider. The costs incurred by the related organization for services, facilities, and supplies furnished to the provider may be included in the provider’s allowable costs; however, the costs may not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

Reasonable Cost Payments for Therapy Services. The basis for determining the reasonable cost of therapy services furnished by outside suppliers is limited to amounts equal to the salary and other costs that would have been incurred by the provider if the services had been performed in an employment relationship, plus an allowance to compensate for other costs, such as travel costs.

Change of Ownership. Providers are required to file a final cost report when certain events indicate a change of ownership (CHOW). The four major events that constitute a CHOW include: (1) a change in the composition of a partnership; (2) a sale of an unincorporated sole proprietorship; (3) a statutory merger or consolidation of two or more corporations; and (4) the leasing of all or a part of a provider’s facility.

Cost Related to Patient Care. Although there now are prospective payment systems or fee schedules for most provider costs related to Medicare patients, the Medicare reasonable cost policies described in the Provider Reimbursement Manual (PRM) are followed by providers that submit cost reports. The cost reports are used by the Medicare agency to calculate payment rates for each type of service paid under a PPS. Costs not included in the prospective payment system (PPS) for hospital inpatient services are listed at 42 C.F.R. §412.2. The annual updates in the Federal Register for the PPS regulations also describe which categories of care continue to be paid on a reasonable cost basis.

Cost Apportionment

Introduction. To determine how to divide the total allowable costs of a provider’s services between Medicare beneficiaries and non-Medicare patients, the regulations provide for a cost allocation and apportionment system designed to separate the apportionment of routine costs from the apportionment of other costs. The process for allocating the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered is referred to by the Medicare program as “cost finding.”

Determination of Cost of Services to Beneficiaries. The total allowable costs of a provider are to be apportioned between program beneficiaries and other patients in such a way that the share of these costs borne by the Medicare program will be based on services received by program beneficiaries. The three methods for apportionment to determine the cost of services to beneficiaries are: (1) the departmental method, (2) the carve-out method, and (3) the cost per visit by type-of-service method.

Charges Included in “Beneficiary Charges” and “Total Patient Charges.” When the ratio of “beneficiary charges” to “total patient charges” is used as a basis for the apportionment of costs, charges related to noncovered items or services (e.g., charges for personal comfort items) must be excluded both from “total patient charges” and from “beneficiary charges” in computing the ratio applied to allowable costs.

Simplified Reimbursement of Skilled Nursing Facilities. The “reasonable cost” approach of the Medicare program prior to the implementation of prospective payment created many difficulties for skilled nursing facilities. Complaints about the “reasonable cost” approach included the complexities of cost-finding and record keeping. Under the Medicaid program the states generally established per diem or monthly rates for patients receiving skilled nursing care.

RCC Ratios. An RCC ratio—ratio of “beneficiary charges” to “total charges” is the ratio of (1) inpatient charges to Medicare beneficiaries for services of a revenue-producing department or center, to (2) the inpatient charges to all patients for that department or center during an accounting period.
Direct Apportionment of Malpractice Costs to Medicare. This section provides an overview of the allocation of provider malpractice insurance costs. Unlike other costs, malpractice costs were based on the dollar ratio of a provider’s paid Medicare malpractice losses to its total paid malpractice losses for the current reporting period and the preceding four-year period.

PS&R Report. Each Medicare administrative contractor is provided a standard Provider Statistical and Reimbursement System (PS&R) to interface with provider billing form CMS-1450. The system provides reports to be used in developing and auditing provider cost reports and related data accumulation operations. Providers also must use the reports in preparing cost reports and providers must be able to explain any variances between the PS&R report and the cost report.

Cost Finding

Introduction. Providers must maintain sufficient financial records and statistical data for proper determination of costs payable. Cost data has to be based on one of the approved methods of cost finding and, except in the case of government institutions operating on a cash basis, the accrual basis of accounting must be used.

Recordkeeping Requirements. Prior to any payments being made to a newly certified provider, the Medicare administrative contractor (MAC) must determine that the provider has adequate recordkeeping capability, sufficient for determining the cost of services furnished to Medicare beneficiaries. A newly participating provider of services must make available for examination its fiscal and other records, for the purpose of determining the provider’s ongoing recordkeeping capability, and to inform the MAC of the date its initial cost reporting period will end.

Allocation and Reclassification of Costs. Decisions involving allocation and reclassification of costs generally are: (1) disputes over the bases to be used in allocating various costs, and (2) reclassification of costs from one cost center to another. Although the Medicare regulations contain no provisions that address these issues, there are a number of references in the Medicare instructions applicable to the bases of allocation to be used.

Substitute Worksheets and Schedules. Substitute cost reporting forms may be accepted for use instead of the official CMS forms; however, the substitute forms many not be used until they have been reviewed and accepted by the CMS Central Office. If a provider chooses to submit a substitute cost reporting form on an electronically prepared vendor system, that vendor system must be approved by the CMS Central Office before that substitute form can be used.

Labor/Delivery Room Days. A maternity inpatient in the labor/delivery room at midnight is not included in the census of inpatient routine care if the patient has not occupied an inpatient routine bed at some time since admission. If the patient is in the labor room at the census but had first occupied a routine bed, a routine inpatient bed day is counted, in Medicaid and total days, for DSH purposes and for apportioning the cost of routine care on the cost report.

Providers that participate in the Medicare program and receive payments under Parts A and B are subject to audit of payments applicable to services rendered to Medicare beneficiaries.

Cost Report Appeals

Introduction. Appeals of cost report determinations must follow specific administrative procedures that ensure disputes are presented to various government agencies for proper resolution. The administrative review process prevents unnecessary intervention into CMS’ decision-making authority, provides CMS with an opportunity to correct its errors, affords district courts the benefit of CMS’ expertise, and establishes a factual record for the courts.

Provider Audits. Providers that participate in the Medicare program and receive payments under Parts A and B are subject to audit of payments applicable to services rendered to Medicare beneficiaries. The primary goal of an audit or adjustment is to arrive at a correct settlement of the cost report, while preserving the provider’s interests and rights.

Audit Principles. Providers are required to maintain sufficient financial and statistical data for proper determination of costs payable under Medicare, which must be capable of verification by qualified auditors. All provider costs applicable to Medicare beneficiaries are subject to audit under the program.
Frequency, Necessity, and Scope of Audit. Contractors must notify each provider that all submitted cost reports are subject to a desk review or an audit. If the provider fails to submit a cost report timely or if the cost report is rejected because it is not acceptable, the contractor should suspend payments. The desk review is an analysis of the provider’s cost report to determine its adequacy and completeness, as well as the accuracy and reasonableness of the data contained within the report. Generally, providers selected for audit represent the greatest risk for incorrect payments.

Who Can Perform Audits? Audits of provider costs may be made by qualified employees of an intermediary or by professional accounting firms that have contracted with intermediaries to perform audits. The contractor may rely on work of other auditors in situations in which the scope of this work relates to issues that have been scoped for the Medicare field audit; however, the contractor must ensure the quality of the other auditors’ work by performing appropriate tests or by other acceptable methods.

Time for Completing Audits. CMS expects contractors to settle all cost reports that are not scheduled for audit within 12 months of acceptance of a cost report by issuing a notice of program reimbursement (NPR). If the contractor audits a cost report, the NPR must be issued to the provider within 60 days of the exit conference or within 60 days after the audit adjustments are finalized if an exit conference is waived. Unless there are documented extenuating circumstances, the contractor has up to 12 weeks from the pre-exit conference for the finalization of the audit adjustments.

PPS Hospital Audit Guidelines. An audit program provides the procedures that auditors must follow to achieve the audit objectives. The contractor should have a specific audit program for each field audit that it performs that reflects the issues contained in the scoping document.

IRS Guidelines for Tax-Exempt Status of Not-for-Profit Hospitals. Most not-for-profit hospitals are exempt from federal income tax if they are organized and operated exclusively for charitable purposes. To qualify for the exemption, a hospital must meet a community benefit standard.

Provider-Based Physicians

Introduction. Payments for physicians who furnish services in a provider setting are governed by regulations. It is necessary to distinguish between the medical and surgical services rendered by a physician to an individual patient, which are paid under Part B, and provider services (including a physician’s services for the provider) that are paid under Part A.

Section XIV.—HIPAA and HITECH

HIPAA

Introduction. The federal government has established national standards for the security and privacy of protected health information. All health care providers as well as all health plans, health information clearinghouses and government health programs including Medicare, must conform with the privacy and security regulations.

Releases of Protected Health Information. HIPAA privacy standards establish guidelines for covered entities and business associates concerning the release of protected health information (PHI) to other organizations and individuals.

De-identifying Data. Protected health information that has identifying information removed may be released without obtaining an authorization from the patient.

Patient’s Right to Access, Amendment and Accounting. HIPAA requires that health care providers (covered entities) allow patients to view, amend and receive an accounting of individuals and groups that have received their individually identifiable health information.

Securing Protected Health Information. Covered entities are required to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the health information they maintain. Security measures sufficient to reduce the identified risks and vulnerabilities must be implemented.

Enforcement. The HIPAA privacy and security regulations are enforced by the Office of Civil Rights (OCR) in the Department of Health and Human Services (HHS). OCR enforces the Privacy Rule in several ways: by investigating complaints filed with it, conducting compliance reviews to determine if covered entities are in compliance, and performing education and outreach to foster compliance with the Privacy Rule’s requirements.

Disclosure of Information Under the Privacy Act. The Privacy Act of 1974 provides safeguards for individuals against an invasion of privacy by federal agencies by restricting the release of individually identifiable medical data maintained by CMS, HHS or Medicare administrative contractors.

The Patient Safety Act. The Patient Safety and Quality Improvement Act of 2005 establishes a voluntary reporting system designed to enhance the data available to assess and resolve patient safety and health care quality issues.
HITECH

Electronic Health Records. The Health Information Technology for Economic and Clinical Health (HITECH) Act authorizes payment incentives under Medicare for the adoption and use of certified electronic health record technology by health care providers.

Meaningful Use. The criteria for meaningful use are based on a series of specific objectives, each of which is tied to a measure that allows eligible professionals and hospitals to demonstrate that they are meaningful users of certified EHR technology.

Certification of Technology for Electronic Health Records. The Office of the National Coordinator for Health Information Technology uses a permanent certification program to authorize organizations to test and certify complete Electronic Health Records (EHRs) and/or EHR Modules, which will make certified EHR technology available prior to the date on which health care providers seeking incentive payments may begin demonstrating meaningful use of certified EHR technology.

Section XV.—Medicaid—Eligibility

Introduction to Medicaid. Medicaid provides assistance with medical expenses for certain low-income individuals and families. The federal government matches state expenditures. Within limits set by federal statutes and regulations, states set their own standards for eligibility, the services available and payment to providers.

Coverage Groups

Eligibility Categories. To be eligible for Medicaid, an individual must fit within one of the following covered categories: low-income children and their caretaker relatives, individuals with disabilities and the elderly, aged 65 and above. Some groups within each of these categories must be covered, while states may choose whether to cover people in the same general category with higher incomes.

Mandatory Groups. Federal law requires state Medicaid programs to cover individuals in specific classifications within the three categories of low-income families with children, individuals over age 65 and individuals with disabilities. Each group is subject to specified income limitations.

History and Overview of the Eligibility of Children and Families. Until 1996, Medicaid eligibility for low-income families with children was tied to receipt of cash assistance through Aid to Families with Dependent Children (AFDC). The Medicaid regulations have not been amended to reflect the 1996 change.

Mandatory Coverage of Low-Income Families with Children. State Medicaid programs must provide assistance to pregnant women, infants, and children through six years of age with incomes up to 133 percent of the federal poverty level (FPL). From age six through age 19, only children with incomes up to 100 percent of FPL must be covered.

To be financially eligible for Medicaid, the applicant must have both income and resources under the limits set by the Medicaid agency.

Mandatory Coverage of Pregnant Women and Newborns. State Medicaid plans must cover pregnant women with incomes up to 133 percent of the federal poverty level (FPL). Coverage continues for 60 days after the end of the pregnancy and the remainder of that calendar month. If Medicaid covers the birth, infants with family incomes up to 133 percent of FPL are also covered for one year without additional documentation.

Mandatory Coverage of Caretaker Relatives. The parent or caretaker relative of an eligible child must be covered under a state’s Medicaid program if the parent would have qualified for Aid to Families with Dependent Children (AFDC) under the state’s standards in effect on July 16, 1996, immediately before welfare reform.

Mandatory Coverage of the Aged, Blind, and Disabled. State Medicaid programs must provide coverage to eligible individuals who are at least age 65 or who are blind or disabled. In general, an individual is disabled if he or she cannot engage in gainful employment. The standard for Supplemental Security Income (SSI) often is used to measure disability for Medicaid purposes. However, there are a number of groups who no longer meet the SSI criteria who still must be covered by Medicaid.

Mandatory Coverage of Medicare Beneficiaries. State Medicaid programs must provide assistance to certain low-income Medicare beneficiaries. Medicaid beneficiaries with incomes up to 100 percent of
the federal poverty level (FPL) and who qualify for Medicaid under another eligibility category may receive complete Medicaid coverage; these individuals are “full benefit dual eligibles.” Qualified Medicare beneficiaries (QMBs), Specified Low-income Medicare beneficiaries (SLMBs) and Qualifying Individuals (QIs) have incomes up to 100 percent, 120 percent and 135 percent of FPL, respectively, and resources below a limit discussed below. The Medicaid benefits for these individuals consist of payment of part or all of their Medicare premiums, deductibles and copayments.

**Mandatory Coverage of Aliens.** Most immigrants who entered the United States on or after August 22, 1996 are not eligible for Medicaid at all until they have been permanent residents for five years. Thereafter, they must be covered if they belong to any of the mandatory eligibility groups. Certain veterans and those in active military service, along with their spouses and dependents, and certain individuals with refugee or asylum status, are not subject to the five year waiting period. Undocumented individuals—noncitizens who are not lawfully admitted to the United States—must be covered for emergency care up to the point that the condition is stabilized. Otherwise, state Medicaid programs are not required to cover undocumented residents at all.

**Optional Eligibility Groups.** State Medicaid programs may choose to make benefits available to additional groups. Most of the optional groups are similar to the mandatory groups but have slightly higher incomes. Others are individuals with a particular condition, such as cancer of the breast or cervix, whose benefits may be limited to services related to the particular condition.

**Optional Groups Without Federal Participation.** Until enactment of the health reform legislation in 2010, states could not receive any federal funds for coverage of populations not discussed above without a waiver from the Secretary.

**Conditions of Eligibility**

**Persons Eligible for Payment.** Medicaid beneficiaries, other than children, have obligations to the Medicaid agency, specifically: notifying the agency of changes in income or other factors affecting their eligibility and cooperating with the agency in identifying and locating third parties who may be liable for their medical expenses. The agency may apply additional requirements to all beneficiaries that are not prohibited by Medicaid law.

**Financial Eligibility.** To be financially eligible for Medicaid, the applicant must have both income and resources under the limits set by the Medicaid agency. Certain forms of income are not counted, and certain expenses may be subtracted from income. Both income and resource limits differ depending on the category of eligibility.

**Transfers of Property and Long-Term Care.** The income limits for Medicaid eligibility are higher for applicants who need long-term care in an institution than for other beneficiaries. Medicaid law attempts to balance the interest of couples in not leaving a community spouse destitute and the interest of the public in preventing individuals with assets from shifting the cost of their care to the state.

**Age.** Medicaid law classifies beneficiaries by age with respect to both children and individuals age 65 and over. Children must be covered until age 19, and states have the option to cover children up to age 21. Certain services must be available to children through their 21st year.

**Residence.** State Medicaid programs must serve any eligible person who resides in the state without any minimum period of residence. They must provide assistance to homeless individuals who have no permanent address.

**Citizenship or Immigration Status.** Citizens who meet the categorical and financial requirements may not be denied Medicaid. In general, citizens who apply for Medicaid for the first time must document their citizenship unless they are exempt. State Medicaid agencies must help applicants to obtain documents through data matching or other means. Most immigrants lawfully living in the United States need not be covered during the first five years of residence, but states may choose to cover pregnant women and children.

**Institutional Status.** Most individuals living in prisons or other nonmedical institutions are not eligible for Medicaid. Individuals living in “institutions for mental diseases” are not eligible unless they are under age 21 or over age 65.

**Blindness.** Medicaid programs must cover individuals who are blind. The extent of blindness usually must be determined medically.

**Disability.** Individuals with disabilities must establish that their disability meets the medical standards of the SSI program, the standards that applied when they first were found eligible for Medicaid, or any more restrictive standards that the state applied before 1972. A medical examination by the appropriate specialist is required.

**Section XVI.—Medicaid—Medical Care and Services**

**Medical Care and Services.** Medical assistance, commonly called Medicaid, includes payment for and/or provision of particular services. In general, all covered services are available to members of mandatory eligibil-
ity groups. However, in recent years, Congress has authorized the states to provide specified benefits to members of specific groups, such as cancer treatment for women with cancer of the breast or cervix, who may not be eligible for other services. Medicaid also includes assistance with premiums for group health insurance and cost sharing for Medicare beneficiaries.

**Requirements Applicable to All Services.** The underlying principle behind the requirements for coverage of services is evenhandedness. People in similar situations should receive similar treatment, and services needed by most beneficiaries should be available to everyone in the same eligibility category and income level regardless of where they live in the state or which caseworker they have.

**Equality of Access to Medical Care.** Members of the same eligibility group must have access to the same medically necessary services. Services available to individuals with higher incomes must also be available to individuals with lower incomes in the same eligibility category.

**Quality and Sufficiency of Medical Care.** State Medicaid programs may impose reasonable limitations on the amount, duration and scope of covered services. The limitations must apply equally to all individuals in the same eligibility category. The limits on the availability of a mandatory service for an eligible individual must be consistent with the purpose of the program.

**Free Choice of Medical Vendor.** The Medicaid agency must allow a beneficiary to see any willing provider that participates in the state’s Medicaid program unless the beneficiary is enrolled in a managed care organization. Beneficiaries enrolled in managed care plans may be restricted to providers in the plan’s network for services other than family planning.

**Mandatory and Optional Services.** Specified services must be available to members of the categorically needy eligibility groups, both the mandatory groups and the optional groups whose eligibility is based on their status as low-income families with children, the elderly and disabled individuals. If a state Medicaid program covers the medically needy, a smaller list of services must be offered.

**Inpatient Hospital Services (Other than Services in an Institution for Mental Diseases).** Inpatient hospital services must be included in any Medicaid program unless the beneficiary is enrolled in a managed care organization. Beneficiaries enrolled in managed care plans may be restricted to providers in the plan’s network for services other than family planning.

**Outpatient Hospital Services.** Outpatient hospital services are a mandatory Medicaid benefit for both the categorically needy and the medically needy.

**Rural Health Clinics.** Rural health clinics provide outpatient care in medically underserved areas. State Medicaid programs must cover their services.

**Federally Qualified Health Center and Other Ambulatory Services.** Medicaid programs must cover the services of federally qualified health clinics (FQHCs) for both categorically needy and medically needy beneficiaries. FQHCs are similar to rural health clinics except that they are located in urban areas with a shortage of available health professionals.

**State Medicaid programs must offer early and periodic screening, diagnosis, and treatment (EPSDT) services to categorically needy individuals under age 21.**

**Other Laboratory and X-ray Services.** Laboratory and x-ray services are required for the categorically needy. If the state plan covers the medically needy, laboratory and x-ray services must be included. These services may be furnished at an outpatient hospital, rural health center, federally qualifying health center or other provider with appropriate certification.

**Nursing Facility Services (Other than Services in an Institution for Mental Diseases) for Individuals 21 or Older.** State Medicaid programs must offer nursing facility (NF) services to categorically needy beneficiaries who are at least 21 years of age. The NF may not be an institution for mental diseases (IMD). Coverage of NF services for the categorically needy under 21 and for the medically needy is optional, but most states cover NF care for these groups.

**Early and Periodic Screening, Diagnosis, and Treatment Services for Individuals Under 21.** State Medicaid programs must offer early and periodic screening, diagnosis, and treatment (EPSDT) services to categorically needy individuals under age 21. If a state plan covers medically needy individuals, it must include EPSDT for all eligible individuals under age 21. The purpose of EPSDT is to discover physical and mental conditions or developmental delays and to correct or ameliorate any defects or chronic conditions discovered.

**Abortion and Family Planning Services.** State Medicaid programs must offer family planning services and supplies to all categorically needy individuals of childbearing age, including minors considered to be...
sexually active. Family planning services must be available to eligible pregnant women through the 60th day following the end of the pregnancy and the remainder of that calendar month. Sterilizations may be covered; special procedures are required in order to assure that the sterilization is voluntary.

Physicians’ Services and Certain Dentists’ Services. State Medicaid programs must offer physicians’ services and certain dentists’ services to the categorically needy. Physicians’ services also are among the services from which states covering the medically needy must choose.

Nurse Practitioner Services. If a state licenses nurse practitioners (NPs), coverage of their services is mandatory for the categorically needy. The state plan must specify whether nurse practitioner services are available to the medically needy. Nurse practitioner services are included in the standard benchmark and benchmark-equivalent benefit packages.

Nurse-Midwife Services. If state law licenses nurse-midwives or permits them to practice, state Medicaid programs must offer nurse-midwife services to the categorically needy. Because any coverage of the medically needy must include services for pregnant women, if the state plan covers the medically needy, the services of licensed nurse midwives must be provided.

Optional Services. States have the option to offer many different benefits to their Medicaid beneficiaries. The benefits added in recent years often have been tailored to specific needs, such as noninstitutional long-term care and prevention of chronic diseases.

Optional Services of Various State-Licensed Practitioners. State Medicaid programs may offer to the categorically and medically needy medical care or any other type of remedial care recognized under state law furnished by licensed practitioners within the scope of their practice under state law. Three of the most commonly covered providers are podiatrists, optometrists and chiropractors.

Home Health Services. State Medicaid plans must provide home health services to all individuals age 21 and older, and to individuals under age 21 if nursing facility services are covered. Medically needy individuals also are entitled to home health services if the state’s Medicaid plan offers nursing facility services to them.

Private Duty Nursing Services. States have the option to cover private duty nursing for individuals whose medical condition requires more constant care than would be available in a hospital or other inpatient facility.

Clinic Services. State Medicaid agencies may cover services provided in an outpatient clinic, defined as a freestanding facility that is not part of a hospital.

Dental Services. Dental services are required for individuals under age 21 under the early and periodic screening, diagnosis and treatment (EPSDT) program; however, Medicaid is not required to provide dental care to individuals who have reached age 21.

Physical, Occupational and Speech Therapy and Related Services. State Medicaid programs may provide a variety of rehabilitative therapies as optional services. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders all are specifically authorized. Medicaid programs may include coverage of these therapies in a variety of settings.

Prescription Drugs. Although every Medicaid program includes them, outpatient prescription drugs are an optional Medicaid benefit. State Medicaid agencies must work with a drug utilization committee in the development and modification of their coverage policies. Medicaid programs must have a rebate agreement with every manufacturer whose drugs are covered.

Prescribed Medical Equipment, Supplies and Appliances. Medical equipment, supplies and appliances, eyeglasses and dentures are a mandatory component of the early and periodic screening, diagnosis and treatment (EPSDT) program. Medical equipment, supplies and appliances also are a mandatory component of home health services, which must be available to the categorically needy, but are optional for the medically needy.

Other Diagnostic, Screening, Preventive, and Rehabilitative Services. State Medicaid programs may cover preventive services, such as vaccinations or regular physical examinations’ diagnostic services, rehabilitative services, and the services of other practitioners recognized by the state.

Inpatient Hospital and Nursing Facility Services for Individuals 65 or Older in an Institution for Mental Diseases. Inpatient services in an institution for mental diseases (IMD) are an optional benefit that states may make available only to individuals 65 years of age or over. Residential psychiatric treatment may be made available to individuals under age 21 and sometimes may be extended to age 22. However, inpatient services in an IMD are not covered for anyone between the ages of 21 (or 22 if the patient is in an IMD at age 21) and 65 years.

Services in an Intermediate Care Facility for the Mentally Retarded (Other Than in an Institution for Mental Diseases). Coverage of the services of intermediate care facilities for the mentally retarded is optional for both the mandatory and the optional eligibility groups. If the plan offers these services to any group of Medicaid recipients, however, the services must be available to the mandatory groups.
Inpatient Psychiatric Facility Services for Individuals Under 21. The Medicaid statutes designates inpatient psychiatric facility services for individuals under age 21 as an optional benefit. The facility may or may not be a hospital. If a state plan includes intermediate care facilities for the mentally retarded, it also must cover inpatient psychiatric facility services for individuals under 21.

Hospice Care. Hospice services are an optional Medicaid benefit available to individuals with a terminal illness who have a life expectancy of less than six months. Individuals who elect hospice care give up the right to try for a cure and, instead, receive palliative care to make them as comfortable as possible. Children are not required to waive other treatment options, however.

Tuberculosis-Related Services and Case-Management Services. Individuals with tuberculosis who are income-eligible may receive Medicaid for the treatment of that disease and related conditions under Medicaid law. The law also recognizes a unique service, targeted case management, which is limited to assessing the individual’s needs and arranging for educational, social or other nonmedical services. The case management service does not include any of the direct services arranged.

Respiratory Care Services. Individuals who are dependent on a ventilator at least six hours daily and who need the ventilator and therapy to avoid inpatient care that Medicaid would cover may receive Medicaid in the limited form of respiratory therapy, the ventilator and related services.

Program of All-Inclusive Care for the Elderly (PACE). The Program of All-Inclusive Care for the Elderly (PACE) combines elements of managed care with home and community-based long-term care services. A nonprofit PACE organization serves the frail elderly in a specified geographic area. PACE enrollees must obtain all of their medical care from or through the PACE organization.

Community-Assisted Living and Personal Care Services. Medicaid law has authorized several similar optional benefits intended to help the elderly and individuals with disabilities at home or in the community. Unlike other Medicaid benefits, personal care services consist of assistance with activities of daily living (ADL), such as bathing, moving from one place to another, eating, dressing and using the toilet.

Services Related to Sickle Cell Disease and Other Care Specified by the Secretary. In addition to the testing and treatment of sickle cell disease, states may cover screening, education and genetic testing and counseling to help individuals with the genetic sickle cell trait prevent transmission of the disease to their children and to minimize the risks associated with the disease.

Premium Assistance for Purchase of Benchmark Health Insurance Packages, Employer-Sponsored Coverage or COBRA Continuation Coverage. Medicaid law provides for the payment of part or all of a premium for group insurance rather than payment for actual medical services. The premium for employer-sponsored group insurance may be made by the state to the employer.

Waivers for Research and Demonstration Projects. The Secretary of HHS has authority to waive many requirements of the Social Security Act for research and demonstration projects. Often, Congress directs the Secretary to authorize particular types of demonstration projects in order to test proposed policies, procedures or methods. Many Medicaid benefits and programs began as demonstration projects.

Waivers for Provision of Home- and Community-Based Services. Waivers allow states to provide long-term care in the form of home- and community-based services (HCBS). The waivers allow the states to serve elderly and/or disabled individuals without providing the same services to every other group, or in every location in the state. Some waiver programs are open to individuals who would otherwise require institutional care.

Expanded Optional Medicaid Access to Home- and Community Based Long-Term Care. The Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) added and enhanced the options to provide home- and community-based services (HCBS). The states may amend their Medicaid plans to include self-directed personal assistance and allow beneficiaries to control the use of the funds allotted to them to tailor the services to their individual needs.

Community Living Assistance Services and Supports. The Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) established the Community Living Assistance Services and Supports (CLASS) program, under which individuals may purchase long-term care insurance to pay for assistance to help them remain in the community. Multiple levels of coverage, measured as the per diem payment for services, were to be available. The premiums were to be based on the age of the insured when the policy is purchased as well as the level of coverage.

Medicaid Managed Care. Under Medicaid managed care, the Medicaid agency contracts with a managed care entity to provide comprehensive care for beneficiaries in return for a capitated payment, i.e., fixed periodic payments per enrollee. The managed care entity usually
directs a patient’s care through a primary care physician or case manager, who arranges, controls and monitors the provision of services for the beneficiaries.

Children’s Health Insurance Program. The Children’s Health Insurance Program is targeted to children in households with incomes just above the threshold for Medicaid. A state may add the CHIP onto the Medicaid program or may set up a separate program. CHIP may provide premium assistance for cost-effective employer-sponsored insurance.

Relationship of Medicaid and CHIP to the Health Insurance Exchanges. The Health Insurance Exchanges are intended to make insurance available for individuals and families who earn too much to be eligible for publicly funded programs such as Medicaid or the Children’s Health Insurance Program (CHIP) but have no access to affordable group insurance. Depending on their incomes, these individuals and families may be eligible for assistance with premiums or cost sharing.

Section XVII.—Medicaid—Payment to Providers

Overview of Requirements for Payment to Providers. The state Medicaid plan must contain all of the rates, methodologies and other aspects of payment to providers. The rates must be set in accordance with the procedural requirements of the federal statutes and regulations. Both the rates and the calculations and methods used to set the rates must meet the requirements of federal law and be described in the state Medicaid plan.

Medicaid Improvement Fund. Appropriations for a Medicaid Improvement Fund for the period from 2015 through 2018 have been withdrawn.

Rate-Setting and Payment Limits in General. Both the rates that state Medicaid agencies pay to providers and the methodology for determination of the rates must be included in the state plan and submitted to CMS for approval. The rates must be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. Federal upper limits may apply to rates for some services.

Rate-setting for Inpatient Services. State Medicaid agencies must engage in a public process including notice and an opportunity to submit written comments whenever they set or change rates for inpatient hospital care unless the change is required by federal law or court order. The rates paid to privately owned facilities may not exceed a reasonable estimate of Medicare payment for the services.

Reimbursement for Prescription Drugs. The Medicaid payment for multiple source, or generic, outpatient drugs is subject to federal upper limits. The statute provides parameters within which the Secretary develops the formula for calculation of the limits. Manufacturers must have an agreement to pay rebates to the state agency as a condition of payment. The formula for determination of the rebate also is set by statute. Both manufacturers and state agencies are required to report utilization and prices paid to CMS.

Reimbursement Methods and Requirements in General. Federal laws and regulations govern the time and manner in which state Medicaid agencies pay providers. Providers must be in compliance with conditions of participation, maintain records to support their claims and permit the agency or its agents to enter and examine their books and records.

Reimbursement for Nursing Home Services. Payment issues particular to nursing facilities include payments for reserved beds during a resident’s temporary absence from the facility, hospice services furnished by a nursing facility, and swing bed services, i.e., the provision of nursing facility services by small rural hospitals.

Reimbursement for Inpatient Hospital Services. State Medicaid agencies have discretion to develop their methodologies for payment for inpatient hospital services. Some states use a prospective payment system (PPS) similar to, or modeled on, the Medicare inpatient PPS. Others may use a fee-for-service system. States also are required to make additional payments to disproportionate share hospitals.

Utilization Control and Review and Medical Review. State agencies review the appropriateness and quality of the services furnished to Medicaid beneficiaries to prevent and detect fraud and abuse, to assure that the services are medically necessary, and to develop and implement best practices to improve the services furnished to beneficiaries. Medicaid payment may not be made for provider-preventable conditions.

Cost Sharing by Medicaid Recipients. State Medicaid plans may require beneficiaries above certain income levels to share part of the cost of their care. The cost sharing may take the form of premiums, enrollment fees, coinsurance or deductibles. Medicaid providers may not refuse service to a beneficiary who cannot pay the cost sharing unless the state plan specifically so provides.

Medicaid Payment of Medicare Cost Sharing. Medicaid beneficiaries who are eligible for Medicare receive assistance with their Medicare premiums, copayments and deductibles for Medicare Parts A and B or C.
The extent of the assistance available to a beneficiary depends on his or her income. These beneficiaries receive assistance with their prescription drug expenses through the low-income subsidy under Part D.

Payment to Patients for Physicians’ or Dentists’ Services. A Medicaid agency may pay a beneficiary for the cost of physician or dentist services if the state plan so provides, the request is supported by a bill for services, and the beneficiary is neither receiving nor eligible for cash assistance.

Permissible Provider Collection Activities. Medicaid providers may not bill a beneficiary for any amount other than Medicaid cost sharing, whether or not the state agency has paid promptly. Medicaid providers may not refuse to furnish services to a Medicaid beneficiary who cannot make the cost sharing payment unless the state has amended its plan to allow it. Providers also are bound by state and federal laws governing creditors’ collection efforts.

Medicaid as the Payor of Last Resort. The Medicaid program is the payor of last resort, which means that any other person or entity that is legally responsible for a beneficiary’s medical expenses should either pay first, before Medicaid, or should reimburse the agency for its expenditures.

Liens and Recoveries. State Medicaid agencies may claim a lien against property of a beneficiary or the beneficiary’s estate in limited circumstances, when: (1) a third party tortfeasor is liable for the beneficiary’s expenses; (2) a court has found that benefits have been paid incorrectly; or (3) the agency has paid for long-term institutional care for a beneficiary. If the beneficiary was over age 55 and in a nursing facility, the agency may make a claim against the beneficiary’s estate only after death.

Overpayments to Providers. An overpayment is the difference between the proper Medicaid payment for an item or service and the amount paid to a provider. State Medicaid agencies must recover overpayments to providers. They may do so by deducting the overpayment from amounts payable to the provider or by other means. The state must repay the federal share of an overpayment to CMS.

Third-Party Liability. When another party has a legal obligation to support a Medicaid beneficiary or to pay the beneficiary’s medical expenses, the state Medicaid agency must identify that responsible party and seek reimbursement for any Medicaid expenditures made for the beneficiary. With few exceptions, applicants for and beneficiaries of Medicaid have a legal obligation to assign their rights to the Medicaid agency and cooperate in the effort to seek reimbursement.

Medicaid Payment Demonstration Projects. The Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) requires the Secretary of HHS to establish four demonstration projects for the purpose of improving the quality of Medicaid for patients and providers. The four projects will investigate (1) integrated care around a hospitalization, (2) a Medicaid global payment system; (3) Pediatric Accountable Care Organizations; and (4) Medicaid emergency psychiatric services.

Section XVIII.—Medicaid—Administration and Financing

Administration and Financing of Medicaid

Administration. The Medicaid program is administered jointly by the federal government and the states. The Centers for Medicare and Medicaid Services (CMS), a division of the Department of Health and Human Services (HHS), publishes the regulations implementing the federal law and assures that state programs comply with federal law through its control over state plan provisions and reimbursement of allowable state expenditures.

The Medicaid program is administered jointly by the federal government and the states.

Overview of State Responsibilities. The state Medicaid agency prepares the state Medicaid plan and any amendments for CMS approval and is responsible for the day-to-day administration of the Medicaid program in compliance with federal requirements and the approved state plan. More specifically, the state agency sets standards for eligibility, services covered, provider enrollment, and payment rates. The state agency is responsible for making timely payment to providers and for recovering funds owed to the agency because of third party liability, other liens or overpayments.

Requirements for State Plans. The state Medicaid plan must describe various aspects of the state’s program in detail and must be approved by CMS. Changes to the plan must be submitted to CMS for approval. CMS has
90 days to notify the state of any deficiencies or additional information needed to approve an amendment; otherwise, it is deemed approved.

**Administration by State Agency.** There must be one state agency charged with the administration of the Medicaid program. It may enter into agreements with other state agencies or with local governments but retains ultimate responsibility for compliance with federal law.

**Criteria for State Personnel Administration and Offices.** State Medicaid agencies must comply with the federal standards for personnel administration as well as state laws. The federal government will review the state laws and regulations for compliance with federal law.

**Eligibility: Application, Determination, and Quality Control.** State Medicaid agencies must process applications timely and accurately. They must track their error rates and report them to CMS. They must accept the preliminary determinations of express lane agencies and will be required to coordinate with other agencies and entities as the health reform legislation is implemented.

**Notice, Hearing, and Appeal Concerning Benefits.** The state Medicaid agency must notify applicants and recipients of any adverse action concerning their eligibility for benefits or the extent of benefits available to them. The notice must provide enough information about the decision to allow the beneficiary a meaningful choice whether to appeal. The agency usually must afford the individual an opportunity for a hearing on the denial or adverse action.

**Disclosure of Medicaid Records.** State Medicaid agencies must restrict disclosure of information about applicants and recipients. However, they must disclose information about their practices and procedures and about the results of surveys of facilities.

**Maintenance of Effort.** Maintenance of effort requirements demand that state programs continue their eligibility standards and/or spending at preexisting levels after a change in the law that provides for higher reimbursement for certain groups. Its purpose is to prevent states from reducing their eligibility limits and then raising them again to take advantage of increased reimbursement.

**Records and Reports.** Federal Medicaid law and regulations require the state agencies to make many reports to CMS on a variety of topics. The state agencies also must require reports from providers, contractors and managed care entities.

**Interagency Cooperation.** State Medicaid agencies must have written agreements with and cooperate with other state agencies, including the health care regulatory agency and vocational rehabilitation agency, in order to use government resources efficiently. These arrangements must be described in the state Medicaid plan.

**Contracts with Fiscal Agents, HMOs and Other Entities.** State Medicaid agencies have discretion to contract with private entities to perform some of their duties in the administration of the Medicaid program. These entities may include fiscal agents, program integrity contractors, recovery audit contractors and managed care entities, among others. Each contract must meet general state and federal requirements applicable to government contracting and additional federal regulatory requirements concerning the type of contract involved.

**Medicaid Managed Care.** Under Medicaid managed care, managed care entities (MCEs), including health maintenance organizations (HMOs), prepaid health plans (PHPs), primary care case management organizations or similar entities, contract with the state agency to provide specific services to Medicaid enrollees in their service area in exchange for fixed periodic payments per enrollee. The MCE must meet requirements for solvency, beneficiary protections and network adequacy, among others.

**Provider and Supplier Surveys, Certification, Enforcement, and Appeals.** State Medicaid agencies and/or state health care regulation agencies contract with CMS to survey facilities and certify compliance with Medicare and Medicaid conditions of participation or requirements for coverage. The surveys may take place at initial enrollment, at revalidation, or upon receipt of a complaint. Medicaid providers and suppliers are now subject to the same screening requirements that apply to their enrollment and participation in Medicare.

**Nursing Facility and Skilled Nursing Facility Participation Requirements.** Nursing facilities (NFs) that participate in Medicaid must meet the same conditions of participation as for Medicare. The state survey agencies perform surveys of NFs to certify their compliance at enrollment and renewal, investigate complaints and establish a return to compliance after a deficiency is found.

**Licensing of Nursing Home Administrators.** All nursing facilities participating in Medicaid must be operated under the direction of a nursing home administrator, who must be licensed by a state agency or board that regulates health professionals or facilities.

**Fraud and Abuse.** Medicaid law addresses the problems of fraud and abuse in very similar ways to Medicare law. Additional federal matching funds are available for state agencies to establish and maintain Medicaid Fraud Control Units, and the recovery audit contractor program has been expanded to the states. The new screening requirements for Medicare providers also apply to Medicaid providers.
Federal-State Financial Arrangements

Federal-State Financial Arrangements. The federal government reimburses the states for a percentage of their Medicaid expenditures. To be reimbursable, the expenditures must be consistent with federal law and regulations and with the state Medicaid plan. Providers receiving payment must not be excluded from a federal healthcare program.

Payments to States. The federal government reimburses states for a percentage of their Medicaid expenditures. The percentage, called the federal medical assistance percentage (FMAP), is calculated according to a formula in the statutes. The formula is adjusted each year to account for changes in per capita income. Some expenses may be reimbursed at a higher percentage. Expenditures that do not meet the legal requirements will not be reimbursed at all.

State Financial Participation. The federal government matches states’ Medicaid expenditures. States must contribute their own funds. The states may require other public entities to contribute, and they also may impose taxes on providers. However, at least 40 percent of the nonfederal share must come from the state.

State Medicaid Programs and the Electronic Health Records Initiatives. State Medicaid agencies have two distinct roles in the implementation of electronic health records (EHR). First, they administer the Medicaid EHR incentive payment program, a five-year grant program for Medicaid providers and eligible professionals. The grants subsidize the adoption, implementation and meaningful use of health information technology. In addition, states are to take a leading role in the development of electronic records systems for health information exchanges by upgrading their systems and coordinating with providers, health plans and other agencies involved in federal human services and health care programs. These interoperable systems also must facilitate enrollment in Medicaid, CHIP and the health insurance exchanges when they begin operation in 2014.

State Payments for Medicare Prescription Drug Benefits. All dually eligible beneficiaries, those eligible for both Medicare and Medicaid, must receive their prescription drugs through Medicare Part D. Because Medicare assumed costs of drug coverage for Medicaid beneficiaries that previously were paid by the states, the states are required to reimburse Medicare for some of those costs. These payments are often referred to as clawback payments.
What does it really cost if you get it wrong?

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