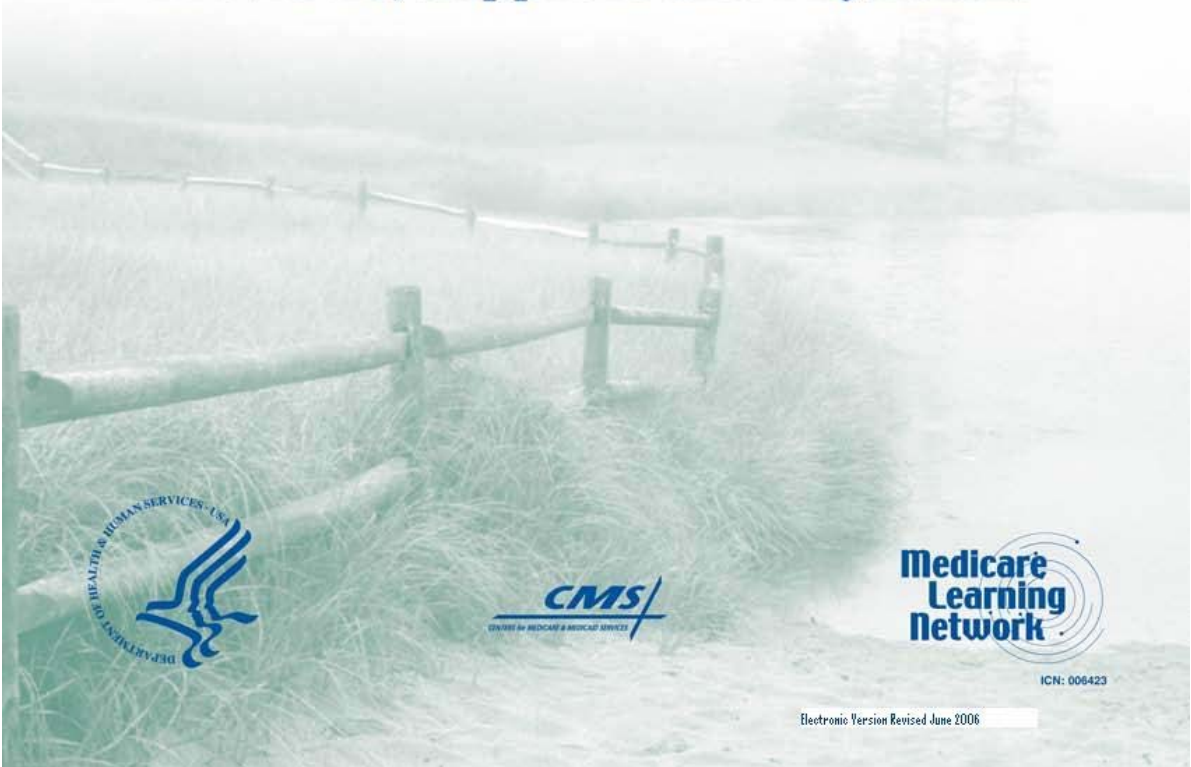


Medicare Guide
to
**Rural Health Services
Information**
for
Providers, Suppliers and Physicians



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PREFACE

The *Medicare Guide to Rural Health Services Information* offers Medicare providers, suppliers, and physicians rural health information and resources in a single source. The following rural health information is included in this publication:

- **Ambulance Services**
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 - Additional Medicare Prescription Drug, Improvement, and Modernization Act Amendments That Impact Ambulance Services
 - Air Ambulance Services

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AMBULANCE SERVICES

The Balanced Budget Act of 1997 mandated the development, through negotiated rulemaking, of a fee schedule (FS) for Medicare Part B ambulance services. The FS began on April 1, 2002 and is being phased-in over a five year period.

Ambulance Fee Schedule Payments

Ambulance FS payments:

- Are based on the lower of the actual billed amount or the ambulance FS amount;
- Include a base rate payment plus a separate payment for mileage;
- Cover both the transport of the patient to the nearest appropriate facility and all items and services associated with such transport where other forms of transport are medically contraindicated;
- Do not include a separate payment for items and services such as oxygen, drugs, extra attendants, and electrocardiograms;
- Include a geographic adjustment factor known as the Geographic Practice Cost Index to reflect the relative costs of furnishing ambulance services in different areas of the country.
- For rural ambulance services, for which the ZIP code for the patient's point of pickup must be reported on each ambulance claim so that the appropriate geographic adjustments can be applied, include:
 - A 50 percent add-on to the mileage payment for the first 17 miles of a *ground* ambulance trip
 - A 50 percent add-on to the total payment (both mileage and base rate) for an *air* ambulance trip

Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established an alternate FS phase-in formula for certain providers and suppliers, in which the FS portion of the blended rate is based on a specified blend of the national FS and a regional FS. If the alternate phase-in formula for a region results in a higher payment, all providers and suppliers in the region will be paid under that formula and their phase-in will last through 2010.

[Additional Medicare Prescription Drug, Improvement, and Modernization Act Amendments That Impact Ambulance Services](#)

In addition to revising the transition formula and schedule for some providers and suppliers, Section 414 of the MMA made several other temporary payment adjustments, with particular attention to ambulance services in rural areas:

- Through December 31, 2006, payments are increased by 2 percent for rural ground ambulance services and by 1 percent for urban ground ambulance services;
- Through December 31, 2008, mileage payments for ground ambulance trips that are longer than 50 miles are increased by one-quarter of the payment per mile otherwise applicable to the trip; and
- Through December 31, 2009, the base payment rate for ambulance trips that originate in rural areas with a population density in the lowest quartile of all rural county populations will be increased. The percentage increase is based on the estimated average cost per trip, not including mileage, in the lowest quartile as compared to the average cost in the highest quartile of all rural county populations.

[Air Ambulance Services](#)

Air ambulance services are covered by Medicare if the patient's condition requires air transport due to time or geographical factors. Medicare covers both fixed wing (airplane) and rotary wing (helicopter) air ambulance services.

Effective January 1, 2005, under Section 415 of the MMA, rural air ambulance services are reimbursed at the air ambulance rate if the services:

- Are reasonable and necessary based on the patient's condition at or immediately prior to transport;
- Meet specified equipment and crew requirements;
- Are deemed medically necessary. An air ambulance is deemed medically necessary when it is:
 - Requested by a physician or other practitioner who reasonably determines that land transport would threaten the patient's survival or health or
 - Furnished according to an approved State or regional emergency medical services (EMS) agency protocol, which recommends use of an air ambulance

The following medical personnel are qualified to order air ambulance services for Medicare beneficiaries:

- Physicians;
- Registered nurse practitioners (from the transferring hospital);
- Physician assistants (from the transferring hospital);
- Paramedic or emergency medical technicians (at the scene); and
- Trained first responders (at the scene).

In most cases, the presumption of medical necessity does not apply if:

- There is a financial or employment relationship between the person requesting the air ambulance (or his/her immediate family member) and the entity furnishing the service, or an entity under common ownership with the entity furnishing the service; or
- In the case of a State or regional EMS agency protocol, such agency has an ownership interest in the entity furnishing the service.

Payment for additional air mileage may be allowed due to circumstances beyond the pilot's control, such as:

- Military base and other restricted zones, air-defense zones, and similar Federal Aviation Administration restrictions and prohibitions;
- Hazardous weather; or
- Variances in departure patterns and clearance routes required by an air traffic controller.

To view the FS, visit www.cms.hhs.gov/AmbulanceFeeSchedule on the CMS website.

To find additional information about ambulance policies, see Chapter 15 of the Medicare Claims Processing Manual (Pub. 100-4) and Chapter 10 of the Medicare Benefit Policy Manual (Pub. 100-2) at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage and the Ambulance Services Provider Center at www.cms.hhs.gov/center/ambulance.asp on the CMS website.

CRITICAL ACCESS HOSPITAL

Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs (Flex Program), under which certain facilities participating in Medicare as hospitals may terminate their hospital status and become Critical Access Hospitals (CAH). CAHs, unlike facilities such as Medicare Dependent Hospitals or Sole Community Hospitals, represent a separate provider type that has its own Conditions of Participation as well as a separate payment method.

Critical Access Hospital Designation

A hospital must meet the following criteria to be designated a CAH:

- Be located in a state that has established a State Flex Program (as of August 2005, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have such a program);
- Be located in a rural area or be treated as rural under a special provision that allows hospitals in urban areas to be treated as rural for purposes of becoming a CAH;
- Provide 24-hour emergency care services, using either on-site or on-call staff;
- Provide no more than 25 inpatient beds;
- Have an average length of stay of 96 hours or less; and
- Be either more than 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR be certified by the State as of December 31, 2005 as being a “necessary provider” of health care services to residents in the area.

Critical Access Hospital Payments

Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries on the basis of 101 percent of their allowable and reasonable costs. Under the Medicare ambulance benefit, CAHs are also paid based on cost for ambulance services if they are the only ambulance supplier within 35 miles. CAHs are not subject to the Inpatient Hospital and Outpatient Prospective Payment Systems.

The Medicare Part A and Part B deductible and coinsurance rules applicable to hospitals also apply to CAHs. All outpatient CAH services other than pneumococcal pneumonia vaccines, influenza vaccines, administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests are subject to Medicare Part B deductible and coinsurance.

Reasonable Cost Payment Principles That Do NOT Apply to Critical Access Hospitals

Payment for inpatient or outpatient CAH services is NOT subject to the following reasonable cost principles:

- Lesser of cost charges; and
- Reasonable compensation equivalent limits.

In addition, payment to CAHs for inpatient CAH services is not subject to ceilings on hospital inpatient operating costs or the 1-day or 3-day preadmission payment window provisions.

Election of Standard Payment Method or Optional (Elective) Payment Method

Standard Payment Method – Cost-Based Facility Services, With Billing of Carrier for Professional Services

Under Section 1834(g) of the Social Security Act (the Act), CAHs are paid under the Standard Payment Method unless they elect to be paid under the Optional (Elective) Payment Method. For cost reporting periods beginning on or after January 1, 2004, outpatient CAH services payments have been increased to the lesser of:

- 80 percent of the 101 percent of reasonable costs for outpatient CAH services OR
- 101 percent of the reasonable cost of the CAH in furnishing outpatient CAH services less the applicable Medicare Part B deductible and coinsurance amounts

Payment for professional medical services furnished in a CAH to CAH outpatients is made by the Medicare Carrier on a fee schedule, charge, or other fee basis, as applies if the services are furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner.

Optional (Elective) Payment Method – Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services (Method 2)

Under Section 1834(g) of the Act, a CAH may elect the Optional (Elective) Payment Method, under which it bills the Medicare Fiscal Intermediary (FI) for both facility services and professional services to its outpatients. However, even if a CAH makes this election, each practitioner furnishing professional services to CAH outpatients can choose whether to reassign billing rights to the CAH and look to the CAH for payment for the professional services or file claims for professional services through their Carrier. To reassign billing rights, individual practitioners must certify using Form CMS 855R, which states that the practitioner will not bill the Carrier for any services rendered at the

CAH once the CAH has received the reassignment. CAHs must forward a copy of the completed form to their FI and the appropriate Carrier and keep the original on file. The CAH must have the practitioner sign an attestation that clearly states that the he or she will not bill the Carrier for any services rendered at the CAH once the reassignment has been given to the CAH. This attestation will remain at the CAH. If this method is chosen by the CAH, the election remains in effect for the entire cost reporting period and applies to all CAH services furnished in the CAH outpatient department during that period by physicians and other practitioners who have not elected to bill the Carrier for their professional services. This election must be renewed yearly based on the cost reporting year. Form CMS 855R can be found at www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage on the CMS website.

As of January 1, 2004, payment for outpatient CAH services under the Optional (Elective) Method is based on the sum of:

- The lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services OR 101 percent of the outpatient CAH services less applicable Medicare Part B deductible and coinsurance amounts AND
- 115 percent of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule for physician professional services. Payment for nonphysician practitioner professional services is 115 percent of the amount that would otherwise be paid for the practitioner's professional services under the Medicare Physician Fee Schedule.

To elect the optional payment methodology or change a previous election, CAHs should notify their FI at least 30 days in advance of the affected cost reporting period.

[Medicare Rural Pass-Through Funding Program for Anesthesia Services](#)

CAHs may participate in the Medicare Rural Pass-Through Program to secure reasonable cost-based funding for certain anesthesia services as an incentive to continue to serve the Medicare population in rural areas. The *Code of Federal Regulations* under 42 CFR 412.113 lists the specific requirements a hospital must fulfill to receive rural pass-through funding from Medicare Part A for anesthesia services. CAHs that qualify for the Certified Registered Nurse Anesthetist (CRNA) pass-through exemptions can receive payment for CRNA professional services regardless of whether the Standard or Optional (Elective) Payment Method is chosen.

[Health Professional Shortage Area Incentive Payments](#)

If the CAH is located within a primary medical care Health Professional Shortage Area (HPSA), physicians who provide outpatient professional services in the CAH are eligible

for HPSA physician incentive payments. Payments to these CAHs for professional services of physicians in the outpatient department will be 115 percent multiplied by the amount under the Medicare Physician Fee Schedule multiplied by 110 percent.

Physician Scarcity Area Bonus Payments

Primary and specialty physicians affiliated with CAHs may also be eligible for a Physician Scarcity Area (PSA) bonus payment of five percent in areas that have few physicians available. One of the following modifiers must accompany the Healthcare Common Procedure Coding System code to indicate the type of physician:

- AG – Primary physician
- AF – Specialty physician

Additional Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Provisions That Impact Critical Access Hospitals

Under Section 405(b), for services furnished on or after January 1, 2005, cost-based reimbursement for costs of obtaining on-call coverage is extended to CAH costs of compensating physician assistants, nurse practitioners, and clinical nurse specialists who are on call to provide emergency services. Under previous law, this coverage was limited to compensation for emergency physicians who were on call to provide emergency services.

Section 405(c) states that periodic interim payments will be paid every two weeks for CAH inpatient services furnished on or after July 1, 2004 for CAHs that apply and qualify for the periodic interim payment method.

Section 405(d) mandates that for cost reporting periods beginning on and after July 1, 2004, each physician or other practitioner providing professional services in the hospital is not required to reassign his or her Medicare Part B benefits to the CAH in order for the CAH to select the Optional (Elective) Payment Method. For CAHs that elected the Optional (Elective) Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of the rule is retroactive to July 1, 2001. For CAHs that elected the Optional (Elective) Payment Method on or after November 1, 2003, the effective date of the rule is July 1, 2004.

Under Section 405(e), beginning on January 1, 2004, CAHs may operate up to 25 beds for acute (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services. Prior to January 1, 2004, CAHs could not operate more than 15 acute care beds or more than 25 beds if it included up to 10 swing beds.

Section 405(g) states that for cost reporting periods beginning on or after October 1, 2004, CAHs may establish psychiatric units and rehabilitation units that are distinct parts (DP) of the hospital. The total number of beds in each CAH DP may not exceed ten. These beds will not count against the CAH inpatient bed limit. Psychiatric and rehabilitation DPs must meet the applicable requirements for such beds in short-term general acute care hospitals, and Medicare payments will equal payments that would be made to general short-term acute care hospitals for these services (e.g., payments under the Inpatient Rehabilitation Prospective Payment System or the Inpatient Psychiatric Prospective Payment System). Payment for services in DP units of CAHs is not made on a reasonable costs basis.

Section 405(h) mandates that effective January 1, 2006, the provision permitting a state to waive the distance requirements for CAH status via State “necessary provider” designation will sunset. Providers with CAH status as “necessary providers” via State designation prior to January 1, 2006 will be grandfathered as CAHs on and after January 1, 2006.

[Grants to States Under the Medicare Rural Hospital Flexibility Program](#)

The Flex Program, which was authorized by Section 4201 of the BBA, Public Law 105-33, consists of two separate but complementary components:

- A Medicare reimbursement program that provides approved cost-based reimbursement for certified CAHs administered by the Centers for Medicare & Medicaid Services; and
- A State grant program that supports the development of community-based rural organized systems of care in the participating states administered by the Health Resources and Services Administration through the Federal Office of Rural Health Policy.

To receive funds under the grant program, states must apply for the funds and engage in rural health planning through the development and maintenance of a State Rural Health Plan that:

- Designates and supports the conversions of CAHs;
- Promotes emergency medical services (EMS) integration initiatives by linking local EMS with CAHs and their network partners;
- Develops rural health networks to assist and support CAHs;
- Develops and supports quality improvement initiatives; and
- Evaluates their programs within the framework of national program goals.

To find additional information about State grants under the Flex Program, visit <http://www.ruralhealth.hrsa.gov> on the Web or call (301) 443-0835.

To find additional information about CAHs and the Flex Program, see the Critical Access Hospital Provider Center located at www.cms.hhs.gov/center/cah.asp and Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) located at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

To access the *Code of Federal Regulations*, visit <http://www.gpoaccess.gov/cfr/index.html> on the Web.

See the Health Professional Shortage Area Section of this guide for additional information about HPSA payments.

To find additional information about PSA bonus payments, see the Physician Scarcity Area Bonus Section of this guide.

See the Swing Bed Section of this guide for additional information about swing beds.

FEDERALLY QUALIFIED HEALTH CENTER

The Federally Qualified Health Center (FQHC) benefit under Medicare was added effective October 1, 1991 when Section 1861(aa) of the Social Security Act was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are “safety net” providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. Medicare pays FQHCs an all-inclusive per visit amount based on reasonable costs with the exception of all therapeutic services provided by clinical social workers and clinical psychologists, which are subject to the outpatient psychiatric services limitation. This limit does not apply to diagnostic services. Medicare also pays Rural Health Clinics (RHC) on the same basis.

Federally Qualified Health Center Designation

An entity may qualify as an FQHC if it is:

- Receiving a grant under Section 330 of the Public Health Service (PHS) Act;
- Receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act;
- Determined by the Secretary of the Department of Health and Human Services to meet the requirements for receiving such a grant (look-alike) based on the recommendation of the Health Resources and Services Administration; or
- An outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Covered Federally Qualified Health Center Services

Payments are made directly to the FQHC for covered services furnished to Medicare patients. Services are covered when furnished to a patient at the Center, the patient's place of residence, or elsewhere (e.g., at the scene of an accident). A FQHC generally provides the following services:

- Physicians' services;
- Services and supplies incident to the services of physicians;
- Services of nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers;
- Services and supplies incident to the services of nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers;
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there exists a shortage of home health agencies;
- Otherwise covered drugs that are furnished by, and incident to, services of physicians and nonphysician practitioners of the FQHC; and
- Diabetes self-management training and medical nutrition therapy for beneficiaries with diabetes or renal disease (effective for services furnished on or after January 1, 2006).

FQHCs also provide preventive primary health services when furnished by or under the direct supervision of a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker. The following preventive primary health services are covered when provided by FQHCs to Medicare patients:

- Medical social services;
- Nutritional assessment and referral;
- Preventive health education;
- Children's eye and ear examinations;
- Well child care, including periodic screening;
- Immunizations, including tetanus-diphtheria booster and influenza vaccine;
- Voluntary family planning services;
- Taking patient history;
- Blood pressure measurement;
- Weight measurement;
- Physical examination targeted to risk;
- Visual acuity screening;
- Hearing screening;
- Cholesterol screening;
- Stool testing for occult blood;

- Dipstick urinalysis; and
- Risk assessment and initial counseling regarding risks.

For women only:

- Prenatal and post-partum care;
- Prenatal services;
- Clinical breast examination;
- Referral for mammography; and
- Thyroid function test.

Federally Qualified Health Center Preventive Primary Services That Are NOT Covered

FQHC preventive primary services that are NOT covered include:

- Group or mass information programs, health education classes, or group education activities including media productions and publications; and
- Eyeglasses, hearing aids, and preventive dental services.

Items or services that are covered under Part B, but which are NOT FQHC services include:

- Certain laboratory services;
- Durable medical equipment, whether rented or sold, including crutches, hospital beds, and wheelchairs used in the patient's place of residence;
- Ambulance services;
- The technical component of diagnostic tests such as x-rays and electrocardiograms;
- The technical component of the following preventive services:
 - Screening pap smears and screening pelvic examinations
 - Prostate cancer screening
 - Colorectal cancer screening tests
 - Screening mammography
 - Bone mass measurements
 - Glaucoma screening
- Prosthetic devices that replace all or part of an internal body organ including colostomy bags, supplies directly related to colostomy care, and the replacement of such devices; and
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes including replacements (if required because of a change in the patient's physical condition).

Federally Qualified Health Center Payments

Under Original Medicare, each Center is paid an all-inclusive per visit rate based on its reasonable costs as reported in the FQHC cost report, with the exception of therapeutic services provided by clinical social workers and clinical psychologists which are subject to the outpatient psychiatric services limitation. This limit does not apply to diagnostic services.

The payment is calculated, in general, by dividing the Center's total allowable cost by the total number of total visits for FQHC services. FQHC payment methodology includes one urban and one rural payment limit. For services furnished on or after January 1 of each year, the payment limit is increased by the Medicare Economic Index applicable to primary care physician services. A FQHC is designated as an urban or rural entity based on definitions in Section 1886(d)(2)(D) of the Social Security Act. If a FQHC is not located within a Metropolitan Statistical Area or New England County Metropolitan Area, the rural limit applies. Rural FQHCs cannot be reclassified into an urban area for FQHC payment limit purposes.

Freestanding FQHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered Center services including FQHC direct costs, any shared costs applicable to the FQHC, and the FQHC's appropriate share of the parent provider's overhead costs. Form CMS-222-92 can be found at www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage on the CMS website. Provider-based FQHCs must complete Worksheet M of Form CMS-2552-96, Hospital Cost Report, in order to identify all incurred costs applicable to furnishing covered Center services. At the beginning of the rate year, the Fiscal Intermediary calculates an interim rate based on estimated allowable costs and visits from the Center if it is new to the FQHC Program or actual costs and visits from the previous cost reporting period for existing FQHCs. The Center's interim rate is reconciled to actual reasonable costs at the end of the cost reporting period. Form CMS-2552-96 can be found in the Provider Reimbursement Manual – Part 2 (Pub. 15-2), Chapter 36, which can be found at www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage on the CMS website.

The cost of the influenza and pneumococcal vaccines and their administration are separately reimbursed at cost settlement. There is a separate worksheet on the Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report to report the cost of these vaccines and their administration. These costs should never be reported on the claim when billing for FQHC services. There is no coinsurance or deductible for these services; therefore, when one of these vaccines is administered, the charges for the influenza and pneumococcal vaccines and their

administration are never included with the visit charges when calculating coinsurance or deductible for the visit. When a physician, physician assistant, nurse practitioner, or certified nurse midwife sees a beneficiary for the sole purpose of administering an influenza and pneumococcal vaccination, he or she may not bill for an office visit. However, the cost can still be included on the cost report.

The cost of the Hepatitis B vaccine and its administration are covered under the all-inclusive rate. If other services, which constitute a qualifying FQHC visit, are provided at the same time as the Hepatitis B vaccination, the charges for the vaccine and its administration can be included in the charges for the visit both when billing and calculating the coinsurance and/or deductible. When a physician, physician assistant, nurse practitioner, or certified nurse midwife sees a beneficiary for the sole purpose of administering a Hepatitis B vaccination, he or she may not bill for an office visit. However, the cost can still be included on the cost report. The charges for the Hepatitis B vaccine can be included on a claim for the beneficiary's subsequent visit and when calculating the coinsurance and/or deductible.

[Medicare Prescription Drug, Improvement, and Modernization Act of 2003](#)

Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that professional services furnished on or after January 1, 2005 by physicians, physician assistants, nurse practitioners, and clinical psychologists who are affiliated with FQHCs are excluded from the Skilled Nursing Facility Prospective Payment System, in the same manner as such services would be excluded if provided by individuals not affiliated with FQHCs.

To find additional information about FQHCs, see Chapter 9 of the Medicare Claims Processing Manual (Pub. 100-4), Chapter 13 of the Medicare Benefit Policy Manual (Pub. 100-2) at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage and the Federally Qualified Health Centers Provider Center at <http://www.cms.hhs.gov/center/fqhc.asp> on the CMS website.

For information on payments to FQHCs in the context of the Medicare Advantage Program, see the Medicare Advantage Program Section of this guide.

See the Rural Health Clinic Section of this guide for additional information about RHCs.

HEALTH PROFESSIONAL SHORTAGE AREA

Effective January 1, 1991, under Section 1833(m) of the Social Security Act, Health Professional Shortage Area (HPSA) incentive payments will be paid to physicians who furnish medical care in geographic areas that have been designated as primary medical care HPSAs by the Health Resources and Services Administration.

Under Section 413 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, beginning on January 1, 2005 HPSA incentive payments will be paid automatically for services furnished in full county primary care geographic area HPSAs and mental health HPSAs. Physicians will no longer need to identify that their services are furnished in a full county primary care geographic area HPSA. An automated file of HPSA designations will be updated on an annual basis, effective for services on or after January 1 of each calendar year. Physicians can self-designate throughout the year for newly designated HPSAs and HPSAs not included in the automated file based on the date of the data run used to create the file.

Health Professional Shortage Area Incentive Payment

The HPSA incentive payment is based on the amount actually paid. Psychiatrists who furnish services in mental health HPSAs with dates of service on or after January 1, 2004 are also eligible for the incentive payment. Physicians may be entitled to a 10 percent HPSA incentive payment and/or a 5 percent Physician Scarcity Area (PSA) bonus payment for the same service as long as the area where the service is performed meets both sets of criteria. The HPSA and PSA payments are based on the paid amount of the claim and are paid on a quarterly basis.

For Professional Component/Technical Component Indicator 4 global services, the professional component and technical component are eligible for the HPSA payment, except for CPT® code 93015 (effective for claims received on or after July 1, 2006).

QB, QU, AQ Modifiers

The QB modifier for a physician providing a service in a rural HPSA and the QU modifier for a physician providing a service in an urban HPSA must be submitted for the following ZIP code areas that:

- Do not fall within a designated full county HPSA;
- Do not fall within the county based on a determination of dominance made by the United States Postal Service;
- Are partially within a partial county HPSA; or
- Are designated after the annual update is made to the automated file.

Effective for claims with dates of service on or after January 1, 2006, the QB and QU modifiers will no longer be accepted. The AQ modifier (Physician providing a service in a Health Professional Shortage Area) will replace the QB and QU modifiers. Claims with prior dates of service must still be submitted with the QB and QU modifiers.

To determine if a modifier is needed, physicians should:

- Visit <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses> on the CMS website to find out whether the location where services were rendered is within a HPSA bonus area;
- Visit the U.S. Census Bureau website at [www.Census.gov](http://www.census.gov) or the Federal Financial Institutions Examination Council website at www.ffiec.gov to determine if the census tract where services are rendered is in an eligible HPSA; and
- Review letters of designation received from Health Resources and Services Administration and verify eligibility of their area for a bonus with their Carrier before submitting services with a HPSA modifier. The letters of designation must be provided as documentation to the Carrier upon request.

To find additional information about HPSAs, see the HPSA/PSA Web Page located at <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses> and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) located at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

See the Physician Scarcity Area Bonus Payment Section of this guide for additional information about PSAs.

HOME HEALTH AGENCY

The Home Health Agency (HHA) must meet the following criteria in order to receive payment for home health (HH) services:

- The patient is an eligible Medicare beneficiary;
- The HHA that provides services to the patient has a valid agreement to participate in the Medicare Program and meets all of the HH Conditions of Participation;
- The patient qualifies for coverage of HH services;
- The services for which payment is claimed are covered and not otherwise excluded from payment; and
- Medicare is the appropriate payer.

Patient Eligibility for Home Health Services

The physician must certify that the patient is confined to his or her home. The patient does not have to be bedridden. However, the condition of the patient should be such that there exists a normal inability to leave home and, consequently, leaving home requires a considerable and taxing effort. If the patient does leave the home, he or she may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to, the following:

- Attendance at an adult day center to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; and
- The receipt of outpatient chemotherapy or radiation therapy.

The following criteria must also be met for patients to qualify for HH services:

- Be under the care of a physician who is qualified to sign the physician certification and home health plan of care;
- Receiving services under a plan of care established and periodically reviewed by a physician; and
- Need for skilled nursing care on an intermittent basis, need for physical therapy or speech-language pathology services, or continued need for occupational therapy.

For purposes of HH benefit eligibility, intermittent means skilled nursing care that is either provided or needed on fewer than 7 days each week or fewer than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Beginning with the last three calendar quarters of 2004 and continuing through calendar years 2005 and 2006, the HH update is based on the HH market basket percentage increase minus 0.8 percent. The annual HH Prospective Payment Systems (PPS) update will be effective in January of each year.

Home Health Prospective Payment System

The unit of payment under the HH PPS is a national 60-day episode rate that pays for all covered services, including medical supplies, on a prospective basis. The episode rate is adjusted by the appropriate wage index and case mix weight. The case mix weight is determined by responses to various items reported on the Outcome and Assessment Information Set. The six HH disciplines included in the 60-day episode rate are:

- Skilled nursing services;
- HH aide services;
- Physical therapy;
- Speech-language pathology services;
- Occupational therapy services; and
- Medical social services.

Also included in the 60-day episode rate are nonroutine medical supplies and therapies that could have been unbundled to Medicare Part B prior to PPS. When an episode contains four or fewer visits, each visit is paid the national per visit payment amount per discipline adjusted by the appropriate wage index. There are other adjustments that may be made to the 60-day episode rate. When a 60-day episode of care is curtailed, the HHA will receive a partial episode payment adjustment. When the patient experiences an unexpected change in condition, the episode payment may receive a significant change in condition adjustment.

As directed by Section 5201 of the Deficit Reduction Act of 2005, rural HH PPS claims will receive a five percent add-on payment for episodes and visits beginning on January 1, 2006 and before January 1, 2007.

To find additional HH information, see Chapter 7 of the Medicare Benefit Policy Manual (Pub. 100-2) available at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage and the Home Health Agency Provider Center located at <http://www.cms.hhs.gov/center/hha.asp> on the CMS website.

HOSPICE

Hospice care is covered under Medicare Part A for the terminally ill beneficiary who meets all the following conditions:

- The individual is eligible for Part A;
- The individual is certified as having a terminal disease with six months or less prognosis if the illness runs its normal course;
- The individual receives care from a Medicare-approved hospice program; and
- The individual signs a statement, which states he or she elects the hospice benefit and waives all rights to Medicare payments for services for the terminal illness and related conditions. Medicare will continue to pay for covered benefits that are not related to his or her terminal illness.

Hospice Payments

Medicare provides the following hospice services for the terminal illness and related conditions:

- Doctor services;
- Nursing care;
- Medical equipment;
- Medical supplies;
- Drugs for symptom control or pain relief;
- Home health aid and homemaker services;
- Physical and occupational therapy;
- Speech therapy;
- Social worker services;
- Dietary counseling;
- Spiritual counseling;
- Grief and loss counseling for the individual and his or her family; and
- Short-term care in the hospital, including respite care.

Medicare will NOT pay for the following services when hospice care is chosen:

- Treatment intended to cure the terminal illness;
- Care from any provider that was not set up by the elected hospice;
- Care from another provider that is the same care that the individual must receive from his or her hospice;
- Services not covered by Medicare; and
- Services that are not medically reasonable and necessary.

Hospice care is available for 2 periods of 90 days and an unlimited number of 60 day periods. The medical director of the hospice or the physician member of the hospice and interdisciplinary group and the individual's attending physician, if the individual has an attending physician, are required for the initial certification of the terminal illness. To be eligible for the Medicare hospice benefit, a beneficiary requires certification of the terminal condition with a prognosis of six months or less if the disease runs its normal course. Certification is required at the initiation of the benefit period and for each subsequent benefit period. If the individual lives longer than six months, he or she is still eligible for hospice care as long as there is recertification of the terminal illness.

To find additional information about hospice, see Chapter 9 of the Medicare Benefit Policy Manual (Pub. 100-2) or Chapter 11 of the Medicare Claims Processing Manual (Pub. 100-4) located at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

MEDICARE ADVANTAGE PROGRAM

An important part of Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) is the Medicare Advantage (MA) Program under Part C of Medicare.

New Options for Beneficiaries

Beginning in 2006, regional Preferred Provider Organization Plans will be available throughout the U.S. In addition, in many rural areas beneficiaries will be able to choose options such as Private Fee-for-Service Plans (PFFS), Health Maintenance Organizations, and Preferred Provider Organization Plans, which are the most popular type of employer-sponsored plan. The MA Program has created new opportunities for rural providers who may choose to:

- Enter into contracts with MA organizations to furnish health care services to MA enrollees. In general, the provisions of these contracts, including payment rates, are matters that MA organizations and providers will negotiate.
- Elect to furnish services to MA enrollees on a non-contract basis. In general, when providers furnish services to MA enrollees on a non-contract basis, the plan pays providers what they would have been paid had they furnished services to Original Medicare Plan enrollees. With the exception of emergency services, non-contract services must be authorized by the MA plan. Providers who elect to furnish services to beneficiaries enrolled in MA PFFS Plans must follow the PFFS Plan terms and conditions of payment.

Strengthening Federally Qualified Health Centers

Federally Qualified Health Centers (FQHC) play an important role in rural health care. Several changes, as a result of the MMA, will help ensure that FQHCs will continue to help meet beneficiaries' health care needs. Beginning with plans offered on January 1, 2006 or later, MA organization contracts must specify that MA organizations will pay FQHCs an amount similar to what they pay other providers for similar services. In addition, for plans beginning on January 1, 2006 or later, the Centers for Medicare & Medicaid Services will make up the difference, if any, between MA organization payments, including beneficiary cost sharing, to FQHCs and 100 percent of FQHCs' reasonable costs for providing care to MA patients served at the Centers.

Beginning on January 1, 2006, the Medicare Prescription Drug Plan or Medicare Part D will provide prescription drug coverage to all beneficiaries under prescription drug plans (PDP) or through MA prescription drug (PD) plans. PDPs will offer only prescription drug coverage. MA PDs will offer prescription drug coverage that is integrated with the health care coverage provided to beneficiaries under Part C of Medicare.

To find additional information about the MA Program, visit www.cms.hhs.gov/HealthPlansGenInfo/ on the CMS website.

MA PD and PDP information can be found at www.cms.hhs.gov/PrescriptionDrugCovGenIn on the CMS website.

The Medicare Part D final rule can be found at <http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-1321.pdf> on the Web.

MEDICARE DEPENDENT HOSPITAL

For cost reporting periods beginning on or after April 1, 1990 and ending before October 1, 1994 or beginning on or after October 1, 1997 and ending before October 1, 2006, a Medicare Dependent Hospital (MDH) is a rural hospital that meets the following criteria:

- Has 100 or fewer beds;
- Is not also classified as a Sole Community Hospital; and
- At least 60 percent of its inpatient days or discharges during the hospital's cost reporting period or periods were attributed to Medicare Part A beneficiaries:
 - For the hospital's cost reporting period ending on or after September 30, 1987 and before September 30, 1988
 - If the hospital does not have a cost reporting period that meets the above, use the hospital's cost reporting period beginning on or after October 1, 1986 and before October 1, 1987 or
 - For at least two of the last three settled cost reporting periods

Medicare Dependent Hospital Payments

Payment for an MDH's inpatient operating costs are the sum of the Federal payment rate plus half of the amount that exceeds the Federal payment rate based on the highest hospital specific base year costs per discharge for Medicare patients from 1982 or 1987, trended forward.

Additional payment guidelines that apply to MDHs include the following:

- Are eligible for a special payment adjustment under the Hospital Inpatient Prospective Payment System.
- If a caseload falls by more than five percent due to circumstances beyond the MDH's control, it may receive payments necessary to fully compensate for fixed costs.
- Do not receive preferential treatment for Disproportionate Share Hospital payments or geographic reclassification.
- The actual payment amount for each bill is determined by the Pricer based on information maintained in Fiscal Intermediary provider specific files. After the cost report is reviewed, lump sum adjustments may be paid.

To find additional information about MDHs, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at

www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL

The Medicare Disproportionate Share Hospital (DSH) adjustment provision under Section 1886(d)(5)(F) of the Social Security Act (the Act) was enacted by Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and became effective for discharges occurring on or after May 1, 1986.

Methods to Qualify for Medicare Disproportionate Share Hospital Adjustment

A hospital can qualify for the Medicare DSH adjustment by using one of the following methods:

- **Primary Method**

The primary method is based on a complex statutory formula that results in the Medicare DSH patient percentage, which is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and Supplemental Security Income (SSI) and the percentage of total inpatient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A.

Medicare Disproportionate Share Hospital Patient Percentage Formula

Disproportionate Share Patient Percentage	Medicare SSI Days	+	Medicaid, Non-Medicare Days
	_____		_____
	Total Medicare Days		Total Patient Days

- **Alternate Special Exemption Method**

The alternate special exception method is for urban hospitals with more than 100 beds that can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local government sources for indigent care (other than Medicare or Medicaid).

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005

Section 402 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that effective for discharges occurring on or after April 1, 2004, the Medicare DSH payment adjustment for rural hospitals with fewer than 500 beds and urban hospitals with fewer than 100 beds has been increased. The cap on the adjustment for these hospitals will be 12 percent, except for hospitals classified as Rural

Referral Centers (RRC). Per Section 502 of the Deficit Reduction Act, as of October 1, 2006 Medicare-Dependent Hospitals (MDH) will also be exempt from the 1 percent cap. The formulas to establish a hospital's Medicare DSH payment adjustment are based on the following:

- Hospital's location;
- Number of beds; and
- Status as a RRC or MDH.

Number of Beds in Hospital Determination

The chart below shows, for Medicare DSH determination purposes, how to determine the number of beds in a hospital:

Medicare Disproportionate Share Hospital Number of Beds Formula

Number of inpatient care bed days attributable to units or wards generally payable under the Inpatient Prospective Payment System excluding beds otherwise countable used for outpatient observation, skilled nursing swing-bed, or ancillary labor/delivery services.

Number of days in the cost reporting period

Medicare Disproportionate Share Hospital Payment Adjustment Formulas

Under Section 1886(d)(5)(F) of the Act, Medicare makes additional Medicare DSH payments to acute hospitals that serve a large number of low-income Medicare and Medicaid patients as part of its Inpatient Prospective Payment System (IPPS). The Medicare DSH patient percentage and adjustment formulas are not applicable to Pickle Hospitals, as defined under Section 1886(d)(5)(F)(i)(II) of the Act. All IPPS hospitals are eligible to receive Medicare DSH payments when their DSH patient percentage meets or exceeds 15 percent.

The following chart depicts the Medicare DSH payment adjustment formulas:

Medicare Disproportionate Share Hospital Payment Adjustment Formulas

STATUS/LOCATION NUMBER OF BEDS	THRESHOLD	ADJUSTMENT FORMULA
URBAN HOSPITALS		
0 - 99 Beds	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)] Not to Exceed 12%
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)] Not to Exceed 12%
100 + Beds	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)] No Cap
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)] No Cap
RURAL REFERRAL CENTERS		
	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)] No Cap
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)] No Cap
MEDICARE-DEPENDENT HOSPITALS (as of October 1, 2006)		
	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)] No Cap
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)] No Cap
OTHER RURAL HOSPITALS		
0 - 499 Beds	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)] Not to Exceed 12%
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)] Not to Exceed 12%
500 + Beds	>=15%, <20.2 %	2.5% + [.65 x (DSH pct – 15%)] No Cap
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)] No Cap

Inpatient care bed days available should be the same as Indirect Medical Education bed days. Available beds may not match the number of licensed beds.

Below is an example of the Medicare DSH patient percentage and adjustment calculations:

Hospital A has 62 beds and is located in an urban area. In fiscal year 2003, it had 5,000 total inpatient days, 1,000 Medicaid/non-Medicare days, 2,000 Medicare Part A days, and 300 Medicare Part A/SSI days. Hospital A has a Medicare DSH patient percentage of 35 percent.

Medicare Disproportionate Share Hospital Number of Beds Formula

Disproportionate Share Patient Percentage	300 Medicare SSI Days	+	1,000 Medicaid, Non-Medicare Days	= .35
	2,000 Total Medicare Days		5,000 Total Patient Days	

Because Hospital A is located in an urban area, has less than 100 beds, and has a DSH patient percentage of more than 20.2%, the formula for determining the Medicare DSH adjustment is: 5.88% + [.825 x (DSH % - 20.2%)]. Urban hospitals with less than 100 beds are subject to a maximum DSH adjustment of 12%.

$$5.88\% + [.825 \times (35\% - 20.2\%)]$$

$$5.88\% + 12.21\% = 18.09\%$$

Hospital A's Medicare DSH adjustment is 12%.

To find additional information about Medicare DSHs, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD RECLASSIFICATIONS

Under Section 1886(d)(10) of the Social Security Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the Inpatient Prospective Payment System. Hospitals must apply to the MGCRB to reclassify by September 1 of the year preceding the year during which reclassification is sought. In general, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year, which begins on October 1. Reclassifications granted by the MGCRB for the wage index will be effective for a three-year period. The *Code of Federal Regulations* under 42 CFR 412.230 through 412.280 contain the regulations applicable to reclassifications by the MGCRB.

To find geographic reclassification applications and instructions, visit <http://www.cms.hhs.gov/MGCRB> on the CMS website.

To access the *Code of Federal Regulations*, visit <http://www.gpoaccess.gov/cfr/index.html> on the Web.

PHYSICIAN SCARCITY AREA BONUS PAYMENT

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 provided a new 5 percent incentive payment to physicians furnishing services in physician scarcity areas (PSA). As of January 1, 2005, Medicare pays primary care physicians who furnish services in a primary care scarcity county and specialty physicians who furnish services in a specialist care scarcity county an additional amount equal to 5 percent of the amount paid for their professional services under the Medicare Physician Fee Schedule. The Congress created the new incentive payment program to make it easier to recruit and retain both primary and specialist care physicians for furnishing services to Medicare beneficiaries in PSAs. A PSA is a U.S. county with a low ratio of primary care or specialty physicians to Medicare beneficiaries.

Definition of Primary Care Physician

A primary care physician is defined as a:

- General practitioner;
- Family practice practitioner;
- General internist;
- Obstetrician; or
- Gynecologist.

Definition of Specialty Care Physician

A specialty care physician is defined as other than a primary care physician.

Providers NOT Eligible for Specialty Physician Scarcity Area Bonus Payment

The following providers are NOT eligible for the specialty physician PSA bonus payment:

- Dentists;
- Chiropractors;
- Optometrists; and
- Podiatrists.

Section 413 of the MMA states that for physician professional services furnished on or after January 1, 2005 and before January 1, 2008, a PSA bonus payment will be available as follows:

- A 5 percent bonus payment (equal to 5 percent of the payment amount for the services provided) will be available to primary and specialty physicians in counties (primary care or specialist care scarcity counties) with the lowest 20 percent ratio of primary care or specialty care physicians to Medicare eligible individuals residing in the county.
- To the extent that it is feasible, a rural census tract of a Metropolitan Statistical Area will be treated as an equivalent area for the purpose of qualifying as a primary care or specialist care scarcity county.
- The same services may qualify as a Health Professional Shortage Area (HPSA) incentive payment and PSA bonus payment, resulting in a physician receiving a total 15 percent bonus payment as long as the area where the service is performed meets both sets of criteria.
- Determination of the bonus payment is made based on the ZIP code where the service was rendered. To find information about ZIP codes where automatic PSA payments will be made, visit www.cms.hhs.gov/HPSAPSAPhysicianBonuses on the CMS website.
- Bonus payments are made on a quarterly basis.
- The technical component of diagnostic services and services that are fully technical are not eligible for the bonus payment.

For Professional Component/Technical Component Indicator 4 global services, the professional component and technical component are eligible for the PSA bonus payment, except for CPT® code 93015 (effective for claims received on or after July 1, 2006).

AR Modifier

In some cases, a service may be provided in a county that is considered a PSA, but the ZIP code is not considered dominant for that area. The bonus cannot be made automatically. In order to receive the bonus payment for these areas, physicians must include the AR modifier (Physician providing service in a Physician Scarcity Area) on the claim.

In order to be considered for the bonus payment, the name, address, and ZIP code of where the service was rendered must be included on all electronic and paper claim submissions.

To find additional information about PSAs, see the HPSA/PSA (Physician Bonuses) Web Page located at <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses> and

Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) located at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

See the Health Professional Shortage Area Section of this guide for additional information about HPSAs.

PRESCRIPTION DRUG PROGRAMS

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 establishes voluntary outpatient Prescription Drug Programs that represent a landmark change to the Medicare Program. The Prescription Drug Programs will significantly improve the health care of millions of beneficiaries, including those in rural areas.

Medicare Prescription Drug Plan

Section 101 of the MMA created Medicare Part D, which provides prescription drug coverage to all beneficiaries electing to enroll in a prescription drug plan beginning on January 1, 2006. Beneficiaries who have Medicare Part A and/or Medicare Part B can enroll between November 15, 2005 and May 15, 2006. To receive coverage beginning on January 1, 2006, enrollment is required by December 31, 2005. Coverage will be effective on the first day of the month after the month of enrollment for beneficiaries who enroll after December 31, 2005.

Defined standard coverage in 2006 includes:

- An estimated average \$32.20 monthly premium (estimated amount; the premium depends on plan bids and which prescription drug plan or Medicare Advantage Plan the beneficiary selects).
- \$250.00 yearly deductible.
- 25 percent coinsurance up to an initial coverage limit of \$2,250.
- Catastrophic coverage once a beneficiary has spent \$3,600 of his or her own money out of pocket for the year. This coverage consists of the greater of:
 - A \$2.00 copayment for generics and preferred multiple source drugs or a \$5.00 copayment for all other drugs or
 - 5 percent of the negotiated price
- 100 percent cost sharing once a beneficiary has reached the initial coverage limit of \$2,250, but before he or she has reached the catastrophic limit of \$3,600 of true out-of-pocket (TrOOP) spending.

Coverage for those beneficiaries with incomes below 135 percent of the Federal poverty level and limited assets includes:

- A reduction in the premium up to the low-income premium subsidy amount for the region, but never to exceed the plan's premium.
- No yearly deductible.
- One of the following three copayment structures until a catastrophic limit is reached
 - A \$2.00 copayment for generics and preferred multiple source drugs or a \$5.00 copayment for all other drugs
 - A \$1.00 copayment for generics and preferred multiple source drugs and a \$3.00 copayment for all other drugs for beneficiaries who are eligible for full benefits under Medicare and Medicaid (full-benefit dual eligible beneficiaries) with incomes under 100 percent of the Federal poverty level and limited savings or
 - No copayment for residents of Skilled Nursing Facilities who are full-benefit dual eligibles
- Once the catastrophic limit of \$3,600 out of pocket is reached, there is no copayment for all prescriptions. The government subsidy for cost sharing counts toward the out-of-pocket threshold for catastrophic coverage.

There is a low income subsidy for beneficiaries with a certain level of assets and incomes between 135 and 150 percent of the Federal poverty level. This subsidy also applies to beneficiaries with incomes below 135 percent of the Federal poverty level if their assets are such that they cannot meet the asset test for incomes below 135 percent of the Federal poverty level, but can meet the higher asset test used for those with incomes below 150 percent of the Federal poverty level. This coverage includes:

- A premium based on a sliding scale from no premium to the full amount of the premium.
- \$50.00 yearly deductible.
- 15 percent coinsurance up to the catastrophic limit. The government subsidy for cost sharing counts toward the catastrophic limit.
- Copayments not to exceed \$2.00 for generic or preferred multiple source drugs or \$5.00 for all other drugs once the catastrophic limit is reached.

A new exception to the anti-kickback statute has been added under which pharmacies are permitted to waive or reduce cost-sharing amounts provided they do so in an unadvertised, nonroutine manner after determining that the beneficiary in question is financially needy or after failing to collect the cost-sharing amount despite reasonable efforts. In addition, pharmacies may waive or reduce a beneficiary's Part D cost-sharing without regard to these standards for Part D enrollees eligible for the low-income subsidy provided they do not advertise that the waivers or cost-sharing reductions are

available. To the extent that the party paying for cost-sharing on behalf of a Part D enrollee is a group health plan, insurance, government-funded health program, or party to a third party payment arrangement with an obligation to pay for covered Part D drugs, that party's payment will not count toward TrOOP expenditures. Thus, payments made for beneficiary cost-sharing by any entity, including a 340B pharmacy, that has an obligation to pay for covered Part D drugs on behalf of Part D enrollees or voluntarily elects to use public funds for that purpose will not count toward that beneficiary's TrOOP expenditures.

[Prescription Drug Discount Card Program](#)

Section 1860D-31 of the Social Security Act states that beginning in June 2004, Medicare beneficiaries can sign up for a Medicare-approved prescription drug discount card to receive discounts off the regular cash price of prescription drugs. All Medicare beneficiaries are eligible for the discount card with the exception of those who have Medicaid drug coverage. Medicare provides \$600 in 2004 and \$600 in 2005 to help pay for prescription drugs for beneficiaries who do not have other drug coverage and whose incomes are not more than 135 percent of the Federal poverty level. This assistance is prorated depending upon the date of application. The Prescription Drug Discount Card Program will end when the Medicare Prescription Drug Plan begins on January 1, 2006.

[Rural Pharmacy Network Access](#)

Rural pharmacies, including those in hospital outpatient departments, Federally Qualified Health Centers, and Rural Health Clinics may contact Part D plans and contract to become Part D network providers under the Any Willing Provider terms and conditions. Any cost shared subsidized by these providers generally will not count toward the beneficiary's out-of-pocket limit.

To find additional information about prescription drug coverage, visit www.cms.hhs.gov/PrescriptionDrugCovGenIn on the CMS website.

QUALITY IMPROVEMENT IN RURAL AREAS

The Centers for Medicare & Medicaid Services (CMS) contracts with Quality Improvement Organizations (QIO) (formerly known as Peer Review Organizations) which conduct quality improvement projects, promote the use of publicly-reported performance data, conduct outreach to beneficiaries and providers, and respond to written complaints from Medicare beneficiaries or their representatives about the quality of services for which Medicare payment may be made, monitor payment errors to reduce fraud and abuse, and ensure that patient rights are protected.

QIOs are required to develop an ongoing process of learning about and contacting organizations in their state that have an interest in health care delivery and health care policy including organizations that represent disadvantaged communities, rural, and non-English speaking populations. These organizations include major religious, community service, civic, union, consumer, public service, and other organizations.

8th Scope of Work

For the first time, the 8th Scope of Work includes a dedicated task for QIOs to work with Critical Access Hospitals (CAH) and rural Prospective Payment System (PPS) hospitals. The three performance improvement areas are:

- Increase the number of CAHs submitting Hospital Quality Alliance (HQA) data to the Centers for Medicare & Medicaid Services clinical warehouse for public reporting via technical assistance from the QIO;
- Improve the performance of CAH locally selected HQA measure(s) via quality improvement assistance; and
- Improve the safety climate in an Identified Participant Group of CAH/PPS rural hospitals.

It is also anticipated that during the course of the contract new rural-sensitive measures will be added to HQA measures and submitted to the clinical warehouse for local benchmarking purposes rather than public reporting.

Organizations interested in finding additional information about QIOs may visit www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp#TopOfPage on the CMS website.

Medicare beneficiaries who have complaints about quality of care issues or want to file an appeal regarding a coverage decision should contact the QIO in their state. QIO telephone numbers can be found at www.medicare.gov/Contacts/Include/DataSection/Questions/SearchCriteria.asp#astep2 on the Medicare website.

RURAL HEALTH CLINIC

The Rural Health Clinic (RHC) Program was established in 1977 to address an inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. The program addresses this problem by providing qualifying clinics located in rural, medically underserved communities. For RHC purposes, any area that is not defined as urbanized is considered non-urbanized. The U.S. Census Bureau defines an urbanized city as a central city of 50,000 or more and its adjacent suburbs. Medicare and Medicaid payments are made on a cost-related basis for outpatient physician and certain nonphysician services. RHCs are located in areas designated by the Bureau of the Census as rural AND by the Secretary of the Department of Health and Human Services OR the State as medically underserved. A RHC cannot be concurrently approved for Medicare as both a Federally Qualified Health Center and a RHC.

Rural Health Clinic Services

RHCs provide the following:

- Services of physicians;
- Services and supplies incident to the services of physicians, services of registered dietitians or nutritional professionals for diabetes training services and medical nutrition therapy (the costs of such services are covered but not as a billable RHC visit), and otherwise covered drugs that are furnished by, and incident to, services of physicians and nonphysician practitioners of the RHC;
- Services of nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers;
- Services and supplies incident to the services of nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers; and
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there exists a shortage of home health agencies.

Rural Health Clinic Designation

To qualify as a Rural Health Clinic, a clinic must be located in:

- A non-urbanized area and in an area with one of the following current designations:
 - A medically underserved area
 - A geographic Health Professional Shortage Area (HPSA) or
 - A population group HPSA

A current designation was designated or redesignated in the current year or one of the previous three years.

A RHC must also:

- Employ a midlevel practitioner who is available to provide services at least 50 percent of the time the clinic is open;
- Provide routine diagnostic and laboratory services;
- Establish arrangements with providers and suppliers to furnish medically necessary services not available at the clinic; and
- Provide first response emergency care.

Rural Health Clinic Payments

Payment for RHC services furnished to Medicare patients is made on the basis of an all-inclusive rate per covered visit. A visit is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, clinical social worker or, in very limited cases, visiting nurse during which a RHC service is rendered.

The cost of the influenza and pneumococcal vaccines and their administration are separately reimbursed at cost settlement. There is a separate worksheet on the Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report to report the cost of these vaccines and their administration. These costs should never be reported on the claim when billing for RHC services. There is no coinsurance or deductible for these services; therefore, when one of these vaccines is administered, the charges for the influenza and pneumococcal vaccines and their administration are never included with the visit charges when calculating coinsurance or deductible for the visit. When a physician, physician assistant, nurse practitioner, or certified nurse midwife sees a beneficiary for the sole purpose of administering an influenza and pneumococcal vaccination, he or she may not bill for an office visit. However, the cost can still be included on the cost report.

The cost of the Hepatitis B vaccine and its administration are covered under the all-inclusive rate. If other services, which constitute a qualifying RHC visit, are provided at the same time as the Hepatitis B vaccination, the charges for the vaccine and its administration can be included in the charges for the visit both when billing and calculating coinsurance and/or deductible. When a physician, physician assistant, nurse practitioner, or certified nurse midwife sees a beneficiary for the sole purpose of administering a Hepatitis B vaccination, he or she may not bill for an office visit. However, the cost can still be included on the cost report. The charges for the Hepatitis B vaccine can be included on a claim for the beneficiary's subsequent visit and when calculating coinsurance and/or deductible.

Encounters at a single location on the same day with more than one health professional and multiple encounters with the same health professional constitute a single visit, except when one of the following conditions exist:

- The patient suffers an illness or injury requiring additional diagnosis or treatment subsequent to the first encounter; or
- The patient has a medical visit AND a clinical psychologist or clinical social worker visit.

Payment is made directly to RHCs for covered services furnished to a patient at the Clinic, the patient's place of residence, or elsewhere (e.g., the scene of an accident). Laboratory tests are paid separately.

The Medicare Part B deductible applies to RHC services and is based on billed charges. Noncovered expenses do not count toward the deductible. After the deductible has been satisfied, RHCs will be paid 80 percent of the all-inclusive interim encounter payment rate, with the exception of all therapeutic services provided by clinical social workers and clinical psychologists which are subject to the outpatient psychiatric services limitation. This limit does not apply to diagnostic services.

Freestanding RHCs must complete CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered Clinic services including RHC direct costs, any shared costs applicable to the RHC, and the RHC's appropriate share of the parent provider's overhead costs. Costs are limited to the national cap for the encounter rate. Form CMS-222-92 can be found at www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage on the CMS website. Provider-based RHCs must complete Worksheet M of Form CMS-2552-96, Hospital Cost Report, in order to identify all incurred costs applicable to furnishing covered Clinic services. Provider-based RHCs that are provider based to a hospital with less than 50 beds are not subject to the national cap and receive full cost per visit for the encounter rate. If the RHC is in the initial reporting period, the all-inclusive rate is determined on the basis of a budget the RHC submits. The budget estimates the allowable cost that will be incurred by the RHC during the reporting period and the number of visits for RHC services expected during the reporting period. Form CMS-2552-96 can be found in the Provider Reimbursement Manual – Part 2 (Pub. 15-2), Chapter 36, which can be found at www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage on the CMS website.

To determine the payment rate for new RHCs and for those who have submitted cost reports, the Fiscal Intermediary (FI) applies screening guidelines and the maximum payment per visit limitation as described below. For subsequent reporting periods, the

all-inclusive rate is determined, at the discretion of the FI, on the basis of a budget or the prior year's actual costs and visits with adjustments to reflect anticipated changes in expenses or utilization.

In general, the payment rate is calculated by dividing the total allowable cost by the number of total visits for RHC services. At the end of the reporting period, RHCs submit a report to the FI that includes actual allowable costs and actual visits for RHC services for the reporting period and any other information that may be required. After reviewing the report, the FI divides actual allowable costs by the number of actual visits to determine a final rate for the period. Both the final rate and the interim rate are subject to screening guidelines for evaluating the reasonableness of the clinic's productivity, payment limit, and psychiatric services limit.

Annual Reconciliation

At the end of the reporting period, the FI determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that professional services furnished on or after January 1, 2005, by physicians, physician assistants, nurse practitioners, and clinical psychologists who are affiliated with RHCs are excluded from the Skilled Nursing Facility Prospective Payment System, in the same manner as such services would be excluded if provided by individuals not affiliated with RHCs.

To find additional information about RHCs, see Chapter 9 of the Medicare Claims Processing Manual and Chapter 13 of the Medicare Benefit Policy Manual (Pub. 100-2) at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

See the Health Professional Shortage Area Section of this guide for additional information about HPSAs.

RURAL REFERRAL CENTER

The Rural Referral Center (RRC) Program was established to support high-volume rural hospitals that treat a large number of complicated cases.

Rural Referral Center Program Requirements

The *Code of Federal Regulations* under 42 CFR 412.96 contains a full description of the criteria for RRCs. In general, a Medicare participating acute care hospital is classified as a RRC if it meets ONE of the following criteria:

- 1) The hospital is located in a rural area AND has the following number of beds available for use:
 - Has 275 or more beds during its most recently completed cost reporting period. If the hospital's bed count has changed, written documentation may be submitted with the application regarding one or more of the following:
 - The merger of two or more hospitals
 - Acute care beds are reopened that were previously closed for renovation
 - Acute care beds are transferred to the Prospective Payment Systems that were previously classified as part of an excluded unit or
 - The hospital expands the number of acute care beds for use and these beds are permanently maintained for inpatients. Such expansion does not include beds in corridors or other temporary beds.

- 2) The hospital shows the following three elements:
 - At least 50 percent of the hospital's Medicare patients are referred from other hospitals or from physicians who are not on the staff of the hospital
 - At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital and
 - At least 60 percent of all services the hospital furnishes to Medicare patients are furnished to patients who live more than 25 miles from the hospital.

A hospital that does not meet the criteria discussed above can alternatively be classified as an RRC if it is located in a rural area and meets the criteria specified in paragraphs 1) and 2) AND at least ONE of the criterion specified in paragraphs 3), 4), or 5) listed below:

- 1) Its case mix index for discharges during the most recent fiscal year ending at least one year prior to the beginning of the cost reporting period for which the hospital is seeking RRC status is at least equal to one of two case mix figures calculated by the Centers for Medicare & Medicaid Services (CMS) in accordance with the *Code of Federal Regulations* under 42 CFR 412.96(c)(1)(ii).
- 2) The number of discharges is at least equal to 5,000 (3,000 for an osteopathic hospital) or a threshold amount set by CMS, in accordance with the *Code of Federal Regulations* under 42 CFR 412.96(c)(2). CMS uses data from the latest available cost report data.
- 3) More than 50 percent of the hospital's active medical staff are specialists who meet the conditions specified in the *Code of Federal Regulations* under 42 CFR 412.96(c)(3).
- 4) At least 60 percent of all discharges are for inpatients who reside more than 25 miles from the hospital.
- 5) At least 40 percent of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital's staff.

To find additional RRC information, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) located at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

To access the *Code of Federal Regulations*, visit <http://www.gpoaccess.gov/cfr/index.html> on the Web.

SOLE COMMUNITY HOSPITAL

A hospital is eligible to be classified as a Sole Community Hospital (SCH) if it is located more than 35 miles from other like hospitals or it is located in a rural area AND meets at least ONE of the following three conditions:

- 1) The hospital is located between 25 and 35 miles from other like hospitals AND meets ONE of the following criteria:
 - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area
 - The hospital has fewer than 50 beds and would meet the 25 percent criterion above were it not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital or
 - Other like hospitals are inaccessible for at least 30 days in each of two out of three years because of local topography or prolonged severe weather conditions
- 2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of two out of three years.
- 3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest hospital is at least 45 minutes.

Sole Community Hospital Payments

Payments to SCHs are paid based on the highest of:

- The Federal rate applicable to the hospital;
- The updated hospital-specific rate based on fiscal year (FY) 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge;
- For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 are based on a blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987 hospital-specific rate; or
- For discharges beginning in FY 2004, the hospital specific rate is 100 percent of the FY 1996 hospital-specific rate.

To find additional information about SCHs, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at

www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

SWING BED

A swing bed hospital is a hospital or Critical Access Hospital (CAH) that has entered into an agreement to use its beds as needed to provide either acute or Skilled Nursing Facility (SNF) care. In order to be granted approval to provide post-hospital SNF care, the following requirements must be met:

- For a hospital:
 - The hospital is located in a rural area
 - The hospital has fewer than 100 beds (excluding beds for newborns and intensive care-type units)
 - The hospital is substantially in compliance with the SNF Conditions of Participation for resident rights, specialized rehabilitative services, dental services, social services, resident activities, and discharge planning
 - The hospital has not had nursing waiver granted as stated in the *Code of Federal Regulations* under 42 CFR 488.54(c) and
 - The hospital has not had a swing bed approval terminated within the two years previous to application for participation

- For a CAH:
 - The facility has been certified as a CAH by the Centers for Medicare & Medicaid Services and
 - The facility provides no more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted.

Rural hospitals that have swing beds increase Medicare patient access to post-acute care beds and maximize the efficiency of their operations by meeting unpredictable demands for acute and long-term care.

Medicare patients must receive acute care as a hospital inpatient for a medically necessary stay of at least three consecutive calendar days in order to qualify for SNF level services.

Effective with cost reporting periods beginning on or after July 1, 2002, short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing bed hospitals must incorporate into the SNF Prospective Payment Systems (PPS). The SNF PPS covers all costs (ancillary, routine, and capital) related to covered services furnished to Medicare patients under Part A, with the exception of certain specified services that are separately billable to Part B. CAHs with swing beds are paid on the basis of reasonable costs.

To find additional information about SNF PPS swing beds, see Chapter 6 of the Medicare Claims Processing Manual (Pub. 100-4) located at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage and the Skilled Nursing Facility Prospective Payment System Swing Bed Providers Web Page located at www.cms.hhs.gov/SNFPSPS/03_SwingBed.asp#TopOfPage on the CMS website.

To access the *Code of Federal Regulations*, visit <http://www.gpoaccess.gov/cfr/index.html> on the Web.

See the Critical Access Hospital Section of this guide for additional information about CAHs.

TELEHEALTH

Effective January 1, 1999, Section 4206 of the Balanced Budget Act (BBA) authorized payment for professional consultations provided via telecommunications to Medicare beneficiaries located in rural Health Professional Shortage Areas (HPSA). Section 223 of the Benefits Improvement and Protection Act expanded the BBA telehealth provision and became effective on October 1, 2001.

Originating Sites

Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site. Originating sites (location of the beneficiary) include the following:

- Physician or practitioner offices;
- Hospitals;
- Critical Access Hospitals;
- Rural Health Clinics; and
- Federally Qualified Health Centers.

The originating site must be located in a rural HPSA or non-Metropolitan Statistical Area county. Entities that participate in a Federal Telemedicine demonstration project approved by (or receiving funding from) the Secretary of Health and Human Services as of December 31, 2000 qualify regardless of geographic location.

Distant Site Practitioners

Practitioners at the distant site who may furnish and receive payment for telehealth services are:

- Physicians;
- Nurse practitioners;
- Physician assistants;
- Nurse midwives;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers; and
- Registered dietitians and nutrition professionals.

Telehealth Services

The current list of Medicare telehealth services include:

- Consultations (Current Procedural Terminology [CPT®] codes 99241 – 99275);
- Office or other outpatient visits (CPT® codes 99201 – 99215);
- Individual psychotherapy (CPT® codes 90804 – 90809);
- Pharmacologic management (CPT® code 90862);
- Psychiatric diagnostic interview examination (CPT® code 90801) (effective March 1, 2003);
- End Stage Renal Disease (ESRD)-related services included in the monthly capitation payment (Healthcare Common Procedure Coding System [HCPCS] codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) (effective January 1, 2005); and
- Medical nutrition therapy (HCPCS code G0270 and CPT® codes 97802 – 97803).

Note: With regard to ESRD-related services, at least one face-to-face, “hands on” visit (not telehealth) must be furnished each month to examine the vascular access site by a physician, clinical nurse specialist, nurse practitioner, or physician assistant.

As a condition of payment, an interactive audio and video telecommunications system must be used that permits real-time communication between the physician or practitioner at the distant site and the beneficiary at the originating site. Asynchronous “store and forward” technology is permitted only in Federal telehealth demonstration programs conducted in Alaska or Hawaii.

Payment is made for the telehealth service provided by the physician or practitioner at the distant site and a telehealth facility fee is made to the originating site. Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service and the telehealth modifier “GT” “via interactive audio and video telecommunications system” (e.g., 99243 GT). In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, submit the appropriate CPT code and telehealth modifier “GQ” “via asynchronous telecommunications system” (e.g., 99243 GQ). Claims for the facility fee should be submitted using HCPCS code Q3014 “Telehealth originating site facility fee.”

To find additional information about Medicare telehealth services, see Chapter 15 of the Medicare Benefit Policy Manual (Pub. 100-2) and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

REFERENCE A RURAL HEALTH WEBSITES

Centers for Medicare & Medicaid Services' Websites

American Indian and Alaska Native

www.cms.hhs.gov/aian

Ambulance Services Provider Center

www.cms.hhs.gov/center/ambulance.asp

CMS Contact Information Directory

www.cms.hhs.gov/apps/contacts

CMS Forms

www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage

CMS Mailing Lists

www.cms.hhs.gov/apps/maillinglists

Critical Access Hospital Provider Center

www.cms.hhs.gov/center/cah.asp

Federally Qualified Health Centers Provider Center

www.cms.hhs.gov/center/fqhc.asp

Health Plans General Information (Medicare Advantage)

www.cms.hhs.gov/HealthPlansGenInfo

Home Health Agency Provider Center located at

www.cms.hhs.gov/center/hha.asp

Hospital Provider Center

www.cms.hhs.gov/center/hospital.asp

HPSA/PSA (Physician Bonuses)

www.cms.hhs.gov/HPSAPSAPhysicianBonuses

Internet-Only Manuals

www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage

Medicare (The Official U.S. Government Site for People with Medicare)
www.medicare.gov

Medicare Geographic Classification Review Board
www.cms.hhs.gov/MGCRB

Medicare Learning Network
www.cms.hhs.gov/MLNGenInfo

Medicare Modernization Update
www.cms.hhs.gov/MMAUpdate

MLN Matters Articles
www.cms.hhs.gov/MLNMattersArticles

OASIS
www.cms.hhs.gov/OASIS

Physician's Resource Partner Center
www.cms.hhs.gov/center/physician.asp

Prescription Drug Coverage
www.cms.hhs.gov/PrescriptionDrugCovGenIn

Private Fee-for-Service Plans
www.cms.hhs.gov/PrivateFeeforServicePlans

Quality Improvement Organizations
www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp#TopOfPage

Regulations & Guidance
www.cms.hhs.gov/home/regsguidance.asp

Rural Health Clinic Provider Center
www.cms.hhs.gov/center/rural.asp

Rural Hospital Flexibility Program Fact Sheet
www.cms.hhs.gov/media/press/release.asp?Counter=331

Skilled Nursing Facility PPS
www.cms.hhs.gov/SNFPPS/03_SwingBed.asp#TopOfPage

Other Organization's Websites

Administration on Aging

www.aoa.govwww.aoa.gov

Agency for Healthcare Research and Quality

www.ahrq.gov

American Hospital Association Section for Small or Rural Hospitals

www.aha.org/aha/key_issues/rural/index.html

Federal Financial Institutions Examination Council

www.ffiec.gov

Government Printing Office

Code of Federal Regulations

www.gpoaccess.gov/cfr/index.html

Health Resources and Services Administration

www.hrsa.gov

Indian Health Service

www.ihs.gov

National Association of Community Health Centers

www.nachc.org

National Association of Rural Health Clinics

www.narhc.org

National Rural Health Association

www.nrharural.org

Rural Assistance Center

www.raonline.org

U.S. Census Bureau

www.Census.gov

REFERENCE B

REGIONAL OFFICE RURAL HEALTH COORDINATORS

Below is a list of contact information for the Centers for Medicare & Medicaid Services Regional Office Rural Health Coordinators who provides technical, policy, and operational assistance on rural health issues.

Region I – Boston

Rick Hoover

E-mail: richard.hoover@cms.hhs.gov

Telephone: (617) 565-1258

States: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region II – New York

Debra Smith

E-mail: debra.smith@cms.hhs.gov

Telephone: (212) 616-2351

States: New Jersey, New York, Puerto Rico, and Virgin Islands

Region III – Philadelphia

Patrick Hamilton

E-mail: patrick.hamilton@cms.hhs.gov

Telephone: (215) 861-4097

States: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia

Region IV – Atlanta

Lana Dennis

E-mail: lane.dennis@cms.hhs.gov

Telephone: (404) 562-7379

States: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region V – Chicago

Christine Davidson

E-mail: christine.davidson@cms.hhs.gov

Telephone: (312) 886-3642

States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region VI – Dallas

Becky Peal-Sconce

E-mail: becky.pealsconce@cms.hhs.gov

Telephone: (214) 767-6444

States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region VII – Kansas City

Robert Epps

E-mail: robert.epps@cms.hhs.gov

Telephone: (816) 426-6538

States: Iowa, Kansas, Missouri, and Nebraska

Region VIII – Denver

Lyla Nichols

E-mail: lyla.nichols@cms.hhs.gov

Telephone: (303) 844-6218

States: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Region IX – San Francisco

Denise McCague

E-mail: denise.mccague@cms.hhs.gov

Telephone: (415) 744-4909

States: Arizona, California, Hawaii, Nevada, Guam, Commonwealth of the Northern Mariana Islands, and American Samoa

Region X – Seattle

Alma Hardy

E-mail: alma.hardy@cms.hhs.gov

Telephone: (206) 615-2387

States: Alaska, Idaho, Oregon, and Washington

REFERENCE C GLOSSARY

A

Abuse

Practices that either directly or indirectly result in unnecessary costs to the Medicare Program. Appears similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally.

Appeal

Complaint a Medicare patient can make if he or she disagrees with a decision to stop services that he or she is receiving or disagrees with a decision to deny a request for health care services or payment for services already received.

B

Balanced Budget Act of 1997

Law that amended Sections of the Social Security Act to include anti-fraud and abuse provisions, program integrity, and preventive care benefits and established the State Children's Health Insurance Program and the Medicare + Choice Program (now known as Medicare Advantage or Part C of the Medicare Program).

Beneficiary

Individual eligible to receive Medicare or Medicaid payment and/or services.

Benefits Improvement and Protection Act of 2000

Law that amended Titles XVIII, XIX and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid programs and the State Child Health Insurance Program.

C

Calendar Year

Yearlong period that runs from January 1 through December 31.

Carrier

Contractor for the Centers for Medicare & Medicaid Services that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments.

Centers for Medicare & Medicaid Services

Federal agency that administers and oversees the Medicare Program and a portion of the State Medicaid Program.

Claim

Request for payment of Medicare benefits or services rendered by a provider or received by a beneficiary.

Code of Federal Regulations

Official compilation of federal rules and requirements.

Coinsurance

Percentage of the Private Fee-for-Service Plan charge for services that the Medicare beneficiary may have to pay after he/she pays any plan deductibles.

Copayment

In some Medicare health plans, the amount that is paid by the beneficiary for each medical service.

Cost-Based Reimbursement

When payment is made to a provider on the basis of their current Medicare-allowable costs.

Covered Service

Reasonable and necessary service rendered to Medicare or Medicaid patients and reimbursable to the provider or beneficiary.

Cost Report

Report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare Program.

Critical Access Hospital

A hospital that is located in a state that has established a State Medicare Rural Hospital Flexibility Program; located in a rural area or be treated as rural under a special provision that allows hospitals in urban areas to be treated as rural for purposes of becoming a Critical Access Hospital (CAH); provides 24-hour emergency care services, using either on-site or on-call staff; provides no more than 25 inpatient beds; has an average length of stay of 96 hours or less; and either is more than 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR be certified by the State as of December 31, 2005 as being a "necessary provider" of health care services to residents in the area.

D

Deductible

Amount a beneficiary must pay before Medicare begins to pay for covered services and supplies.

Department of Health and Human Services

Administers many Federal health and welfare programs for citizens of the U.S.; parent agency of the Centers for Medicare & Medicaid Services.

Distinct Part of an Institution

Refers to a portion of an institution or institutional complex (e.g., a Skilled Nursing Facility, Critical Access Hospital, hospital) that is certified to provide Skilled Nursing Facility, Nursing Facility, psychiatric, and/or rehabilitation services.

Durable Medical Equipment

Medical equipment ordered by a physician or, if Medicare allows, a nurse practitioner, physician assistant or clinical nurse specialist for use in the home; item must be reusable (e.g., walkers, wheelchairs, or hospital beds).

E

Enrollment

Means by which an individual establishes membership in a program or group.

F

Federally Qualified Health Center

Facility that is receiving a grant under Section 330 of the Public Health Service Act, receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the Public Health Service Act, the Secretary of the Department of Health and Human Services has determined that it meets the requirements for receiving such a grant (look-alike) based on the recommendation of the Health Resources and Services Administration, or is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Fee Schedule

Complete list of fees used by health plans to pay physicians and other providers.

Fiscal Intermediary

Contractor for the Centers for Medicare & Medicaid Services that processes claims for services covered under Medicare Part A and most types of claims for services covered under Medicare Part B.

Fiscal Year

Yearlong period that runs from October 1 through September 30.

Fraud

Intentional deception or misrepresentation that an individual knows, or should know, to be false or does not believe to be true and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

H**Healthcare Common Procedure Coding System**

Uniform method for providers and suppliers to report professional services, procedures, and supplies; includes Current Procedure Technology codes, and national alphanumeric codes.

Health Professional Shortage Area

Geographic areas that have been designated as primary medical care where physicians who furnish medical care are entitled to an incentive payment.

Homebound

A patient who is confined to his or her home. He or she does not have to be bedridden. However, the condition of the patient should be such that there exists a normal inability to leave home and, consequently, leaving home requires a considerable and taxing effort.

Home Health Agency

An agency that meets the following criteria in order to receive payment for home health services: the patient is an eligible Medicare beneficiary, the agency that provides services to the patient has a valid agreement to participate in the Medicare Program and meets all of the home health Conditions of Participation, the patient qualifies for coverage of home health services, the services for which payment is claimed are covered and not otherwise excluded from payment, and Medicare is the appropriate payer.

Hospice

Part A coverage for the terminally ill beneficiary who meets all the following conditions: The individual is eligible for Part A; the individual is certified as having a terminal disease with six months or less prognosis if the illness runs its normal course; the individual receives care from a Medicare-approved hospice program; and the individual signs a statement, which states he or she elects the hospice benefit and waives all rights to Medicare payments for services for the terminal illness and related conditions. Medicare will continue to pay for covered benefits that are not related to his or her terminal illness.

M

Medically Necessary

Services or supplies that are: proper and needed for diagnosis or treatment of a medical condition; provided for the diagnosis, direct care, and treatment of the condition; meet standards of good medical practice in the local area; and are not mainly for the convenience of the physician.

Medicare Advantage (formerly known as Medicare + Choice); Part C of the Medicare Program; managed care plan

A set of health care options created by the Balanced Budget Act and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Medicare Dependent Hospital

For cost reporting periods beginning on or after April 1, 1990 and ending before October 1, 1994 or beginning on or after October 1, 1997 and ending before October 1, 2006, is a rural hospital that has 100 or fewer beds, is not also classified as a Sole Community Hospital, and at least 60 percent of its inpatient days or discharges during the hospital's cost reporting period or periods were attributed to Medicare Part A beneficiaries: for the hospital's cost reporting period ending on or after September 30, 1987 and before September 30, 1988; if the hospital does not have a cost reporting period that meets the above, use the hospital's cost reporting period beginning on or after October 1, 1986 and before October 1, 1987; or for at least two of the last three settled cost reporting periods.

Medicare Disproportionate Share Hospital

Hospital that meets certain qualifications under either the Primary or Alternate Special Exemption Method.

Medicare Economic Index

Index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. Since 1992, the Medicare Economic Index is considered in connection with the update factor for the Medicare Physician Fee Schedule.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Comprehensive bill signed by President George W. Bush on December 8, 2003 that expands many parts of the Medicare Program.

O**Outcome and Assessment Information Set**

Group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of Outcome-Based Quality Improvement. The Outcome and Assessment Information Set is performed on every Medicare or Medicaid patient who receives services of approved Home Health Agencies.

P**Part A of the Medicare Program**

Hospital insurance that pays for inpatient hospital stays, care in a Skilled Nursing Facility, hospice care, and some home health care.

Part B of the Medicare Program

Medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A.

Part C of the Medicare Program

See Medicare Advantage.

Part D of the Medicare Program

Prescription drug coverage available to all beneficiaries who elect to enroll in a prescription drug plan beginning on January 1, 2006.

Physician Scarcity Area

U.S. county with a low ratio of primary care or specialty physicians to Medicare beneficiaries.

Physician Services

Services provided by an individual licensed under State law to practice medicine or osteopathy.

Pricer

Software modules in Medicare claims processing systems that are specific to certain benefits and used in pricing claims, most often under Prospective Payment Systems.

Prospective Payment System

Method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.

Q**Quality Improvement Organization; formerly known as Peer Review Organization**

Organization that contracts with the Centers for Medicare & Medicaid Services to conduct quality improvement projects, promote the use of publicly-reported performance data, conduct outreach to beneficiaries and providers, and respond to written complaints from Medicare beneficiaries or their representatives about the quality of services for which Medicare payment may be made, monitor payment errors to reduce fraud and abuse, and ensure that patient rights are protected.

R**Reasonable Cost**

Based on actual cost of providing services including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program. Fiscal Intermediaries and Carriers use the Centers for Medicare & Medicaid guidelines to determine reasonable costs incurred by individual providers in furnishing covered services to Medicare beneficiaries.

Rural Health Clinic Program

Program established to address an inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. The program addresses this problem by providing qualifying clinics located in rural, medically underserved communities. A clinic must be located in a non-urbanized area and in an area with one of the following current designations: a medically underserved area, a geographic Health Professional Shortage Area (HPSA), or population group HPSA.

Rural Referral Center Program

Program established to support high-volume rural hospitals that treat a large number of complicated cases. Requirements under the *Code of Federal Regulations* under 42 CFR 412.96 must be met to be classified as a Rural Referral Center.

S**Skilled Nursing Care**

Level of care that includes services that can only be performed safely and correctly by a licensed nurse.

Skilled Nursing Facility

Facility that meets specific regulatory certification requirements and primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services and does not provide the level of care or treatment available in a hospital.

Social Security Act

Public Law 74-271 that was enacted on August 14, 1935, with subsequent amendments.

Sole Community Hospital

Located more than 35 miles from other like hospitals or it is located in a rural area and meets certain additional conditions.

Swing Bed Hospital

Hospital or Critical Access Hospital that has entered into an agreement to use its beds as needed to provide either acute or Skilled Nursing Facility care and meets certain additional requirements.

REFERENCE D ACRONYMS

BBA	Balanced Budget Act
CAH	Critical Access Hospital
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DP	Distinct Part
DSH	Disproportionate Share Hospital
EMS	Emergency Medical Services
ESRD	End-Stage Renal Disease
FI	Fiscal Intermediary
FQHC	Federally Qualified Health Center
FS	Fee Schedule
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
HH	Home Health
HHA	Home Health Agency
HPSA	Health Professional Shortage Area
HQA	Hospital Quality Alliance
IPPS	Inpatient Prospective Payment System
MA	Medicare Advantage

MDH	Medicare Dependent Hospital
MGCRB	Medicare Geographic Classification Review Board
MLN	Medicare Learning Network
MMA	Medicare Prescription Drug, Improvement, and Modernization Act
PDP	Prescription Drug Plan
PFFS	Private Fee-for-Service
PHS	Public Health Service
PPS	Prospective Payment System
PSA	Physician Scarcity Area
QIO	Quality Improvement Organization
RAF	Rural Adjustment Factor
RHC	Rural Health Clinic
RRC	Rural Referral Center
SCH	Sole Community Hospital
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TrOOP	True Out-of-Pocket