NOSORH
national organization of state offices of rural health

October 31, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Room 445–G
200 Independence Avenue, SW.
Washington, DC 20105

Secretary Sebelius:

The following comments are submitted on behalf of the National Organization of State Offices of Rural Health (NOSORH) in response to the Notice of Proposed Rulemaking (NPRM) regarding Health Insurance Exchanges (HIEs) and Qualified Health Plans (QHPs), published on July 15, 2011.

NOSORH is the national organization of the 50 state offices of rural health. Your consideration of these comments is greatly appreciated.

**Background:**

Under the Patient Protection and Affordable Care Act (PPACA), each state is authorized to establish one or more Health Insurance Exchanges. In the event a state fails to establish an HIE, the federal government will establish an HIE for that state. The purpose of HIEs is to create a marketplace through which individuals and small business can purchase health insurance. HIEs will list Qualified Health Plans that meet federal benefit and service standards and that have also been reviewed and certified by the state.

The NPRM published on July 15th set the minimum standards for states on operations of HIEs as well as minimum standards for the certification of qualified health plans.

Our comments will focus on the requirements a plan must meet in order to be designated as a Qualified Health Plan for purposes of sale through the HIE.

The federal requirements for QHPs are particularly important for rural health. While states are permitted to establish additional standards for QHPs that could address rural needs, to the degree that the federal standards make special provisions for rural health, it will not be necessary to have each state make such provisions. In addition, the federal government will operate HIEs in those states that do not establish their own HIEs. Therefore, federal standards will likely be the only basis for consideration of rural health concerns these states.



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**Minimum Access and Availability Requirements for Qualified Health Plans**

NOSORH believes that Qualified Health Plans (QHPs) must assure that rural residents have reasonable access to adequate numbers of health services, providers and facilities. Providing rural residents with a health insurance policy that does not provide true access to a healthcare provider makes that policy meaningless. Because there is an individual mandate included in the PPACA, failure to set minimum access and availability requirements will likely result in requiring individuals to purchase a health insurance plan that is of little value to rural residents.

Minimum federal requirements for QHPs should address five key considerations:

1. Requirements for Inclusion of Rural Service Areas;
2. Required Network Inclusion of Rural Essential Community Providers (ECPs);
3. Adequate Reimbursement for Rural ECPs;
4. Rural specific network adequacy requirements;
5. Payment incentives for providers to locate or remain in rural underserved areas.

**Requirements for Inclusion of Rural Service Areas**

The proposed regulations recognize in that it is possible for qualified health plans to "cherry-pick" their service areas so as to minimize the cost of services to plan enrollees. However, the regulations only establish a requirement that service areas include whole counties. While this should help prevent so-called "redlining" of high risk neighborhoods within counties, it does nothing to prevent "redlining" between counties.

More specifically, none of the proposed requirements prevent discrimination against rural and frontier areas, which may have poorer health status and higher delivery costs. Without more firmly established federal minimum requirements for rural areas, there may be few, if any, QHPs providing coverage in rural and frontier areas. QHPs may end up limiting their benefits to residents of larger, metropolitan service areas and coverage in rural areas may be limited. This concern is based upon our experience in the early days of the Medicare Advantage program.

Establishing a federal requirement for QHP coverage of rural and frontier areas would be useful in assuring adequate coverage for rural America.

**Recommended Rural Service Area Language:**

States shall establish provisions which assure that QHPs offer coverage to rural and frontier areas, and which assure that multiple QHPs are available for these areas, permitting health plan choice for rural residents.

In addition, in states without a state-established HIE, we believe the federal standards should mandate that all QHPs be required to make their plan available statewide, not just within selected counties. If a healthplan wants access to the Denver market, it should be required to make the plan available in rural Colorado. If a plan wants access to the Seattle market, it must make its plan available in rural Washington. If plan wants access to the Philadelphia or Pittsburgh markets, it must make the plan available in rural Pennsylvania.

**Required Network Inclusion of Rural Essential Community Providers (ECPs)**

The proposed rule requires that a QHP include within its provider network of the QHP a ***sufficient number*** of essential community providers, where available, that serve predominantly low-income, medically underserved



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individuals. The section defines essential community providers as those health care providers defined in section 340B(a)(4) of the PHS Act. Under this definition, essential community providers (ECPs) would include:

**Federally qualified health centers (FQHC) (grant supported and "look-alikes");**
**Critical access hospitals (CAH)**
**Certain Sole community hospitals and rural referral centers**
**Hemophilia treatment centers**
**Native Hawaiian health centers**
**Urban Indian clinics**
**Title X family planning clinics**
**STD clinics**
**TB clinics**
**Certain DSH Hospitals**
**Free-standing children's hospitals;**
**AIDS drug assistance programs**
**Black lung clinics;**
**Ryan White AIDS clinics**

While we believe this is a reasonable starting point for discussions, we would not that the list excludes several providers critical to rural communities.

For example, the list does not include federally certified Rural Health Clinics (RHC). Similarly, there is no requirement for many rural hospitals or for private rural practices. Furthermore, the use of the phrase "*sufficient number*" is vague, and does not ensure participation of many rural ECPs.

We would note that Section 1131 of the PPACA does not stipulate or use the phrase "*sufficient number*" in mandating that ECPs be included in QHPs. We believe strongly that your inclusion of this phrase weakens the meaning of Section 1131. As drafted the language of the regulation could leave out significant numbers of essential rural providers.

The rural safety net is more than just CAHs, FQHCs and certain rural hospitals. Thousands of rural underserved communities rely exclusively on certified Rural Health Clinics to meet their primary care needs. Excluding RHCs from the definition of Essential Community Provider will result on these clinics being excluded from the networks not only jeopardizing their ability to survive, but ensuring that individuals residing in rural underserved areas will have to travel long distances to obtain primary care services. This is unacceptable.

Similarly, many physicians, PAs and NPs in private practice are the principle source or primary care in many rural communities. The ECP makes no provision for these providers or the many rural hospitals that serve rural communities.

We believe the language we recommend below will eliminate the vagueness associated with the phrase "*sufficient number*", and make it consistent with the intent of the Affordable Care Act. It would expand the definition of ECP to include all certified rural health clinics and is consistent with the intent if the PPACA to assure access to care for all populations.

While we appreciate the reluctance to establish a broad, national any willing provider requirement, we believe that with respect to rural service areas, a limited any willing ECP provider requirement is justified. Failure to



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establish such a requirement could have the perverse effect of actually decreasing the availability of healthcare in rural underserved areas rather than improving access to healthcare – the goal of the PPACA.

**Recommended Rural Essential Community Provider Language:**

The definition of "Essential Community Provider" must be modified to include:

(1) Health care providers defined in section 340B(a)(4) of the PHS Act;
(2) All Providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act
(3) All federally certified rural health clinics.

In addition, with respect to rural service areas, we believe a QHP must include within its provider network *all willing essential community providers*. Nothing in this requirement shall be construed to require any health plan to provide coverage for any specific medical procedure provided by the essential community provider.

**Adequate Reimbursement for Rural ECPs**

The required inclusion of ECPs in QHP networks is not the only consideration in assuring adequate service availability for rural residents.

If QHPs fail to provide adequate reimbursement for services, few ECPs would be willing providers, and the network adequacy of any QHP would be questionable. The proposed rules do not make adequate provision for adequate reimbursement levels of ECPs.

The Affordable Care Act makes specific provision for one category of ECP, the federally qualified health center (FQHC). The PPACA specifies that:

> "If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C.1396a(bb)) for such item or service."

Notwithstanding this statutory provision, the proposed rules do not address this required payment level. This section of the law is clearly in conflict with Section 1311(c)(2) of the Act which states that "nothing shall be construed to require a QHP to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of the plan."

Unfortunately, rather than resolve this potential conflict in the proposed rules, comments are solicited.

The PPACA is quite clear in that there are multiple provisions of the law which seek to assure network adequacy in QHPs and health care for the underserved. Therefore, we believe that the federal rules should recognize that the established payment levels of Medicare or Medicaid for essential community providers are what are needed to assure the provision of services for key target populations. In keeping with this line of reasoning, we recommend the following:



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**Recommended Adequate Reimbursement for Rural ECPs Language:**

If any item or service covered by a qualified health plan is provided by an essential community provider (as modified by our recommendation above), to an enrollee of the QHP, the QHP shall pay to that ECP an amount that is not less than the amount of payment that would have been paid to the ECP under the Medicare or Medicaid Program, whichever is greater.

**Rural specific network adequacy requirements**

NOSORH believes that Health Insurance Exchanges must to consider the adequacy of a QHP's provider network before certifying a plan for sale in that market (or service area).

As noted earlier, offering health insurance coverage does nothing for assuring access to healthcare if there is an inadequate number of healthcare providers in the ntework or if the network providers are not located within a reasonable distance for enrollees.

Section 1311 of the PPACA recognizes this need and calls upon the Department of Health and Human Services to establish criteria for certification of QHPs, including criteria for ensuring a sufficient choice of providers for enrollees.

Unfortunately, the proposed rule for HIEs establishes the barest minimum network adequacy provisions for QHPs. There is very little that addresses what must be done to assure adequate service networks in rural and frontier areas. Although the NPRM calls upon QHPs to ensure that enrollees have an adequate choice of providers, this is simply a restating of the language of the PPACA, without substantively addressing the requirement that the Department establish criteria for certification.

Again, as noted earlier, because the PPACA includes a mandate that individuals show evidence of health insurance and requires individuals to purchase a QHP in order to obtain the generous tax incentives available to help lower the cost of health insurance, it is essential that the plans made available for purchase have value to the purchaser. Otherwise, you are requiring an individual to purchase a health insurance policy that has little practice value to that person or family.

The NPRM solicits comments on a potential additional requirement that the Exchange establish specific standards under which QHP issuers would be required to maintain the following:

> (1) Sufficient numbers and types of providers to assure that services are accessible without unreasonable delay; and
> (2) Arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients.

NOSORH does not believe that these requirements should be left up to the HIEs. Rather, we believe that the Secretary should adhere to both the letter and spirit of the PPACA and establish these standards. Failure to do so would be a gross abrogation of responsibility on the part of the Department.

Ironically, CMS has established detailed network adequacy standards for the VOLUNTARY Medicare Advantage program but the Department is effectively taking a pass on minimum network adequacy standards for the mandatory HIE program. This makes little sense from a public policy perspective.



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For the Medicare Advantage program, CMS has affirmatively established criteria which identify the minimum enrollee to provider ratios for primary care, specialty care and facilities (i.e. hospitals). CMS has also identified the minimum accessible distances for each type of provider. There are separate criteria established for multiple urban, near urban and rural areas. There are also criteria for frontier areas – termed Counties with Extreme Access Considerations (CEACs).

We have attached charts detailing the current network adequacy criteria for Medicare Advantage as part of our comments. HHS/CMS uses these criteria to establish county-specific network adequacy requirements for every county in the United States.

We believe it would consistent with the requirements of the PPACA for HHS to establish similar criteria for QHPs. The Department clearly has the capacity to set such criteria for a Medicare population, and could build upon that base to extend analysis for the general population. We recommend the following change in the final rule.

**Recommended Network Adequacy Language:**

The Department of Health and Human Services shall establish and maintain criteria identifying the minimum number of providers and minimum facility capacity required by Qualified Health Plans for its enrollees. These criteria shall specify enrollee to provider and enrollee to facility capacity ratios for all key specialties and facilities. The Depart shall also establish and maintain specific criteria for Qualified Health Plans identifying the maximum travel time and distance for each key provider and facility type.

Criteria shall be established and maintained for the spectrum of urban and rural counties, including counties with extreme access considerations (frontier counties). Based upon these criteria the Department shall establish and maintain Qualified Health Plan network adequacy standards for each county/parish in the United States. Health Insurance Exchanges shall utilize these standards for certifying the network adequacy of each Qualified Health Plan made available by the HIE.

**Payment incentives for providers to locate or remain in rural underserved areas**

Although the proposed rule discusses the need for QHP network adequacy, it does not address how QHPs should respond to parts of the service area with recognized shortages of healthcare providers (physicians, PAs, NPs, mental health, dental health, etc.). These areas have structural shortages of a critical nature and cannot be expected to have adequate provider networks for enrollees. These areas are located in both rural and urban areas.

In recognition of this problem, Medicare provides a financial payment differential for services delivered by private providers in certain underserved locations. These payments are separate from the special reimbursement approaches used for ECPs, and provide an incentive for private providers not eligible for ECP reimbursement programs. It would be reasonable to extend this approach to QHPs, and to require HIEs to certify QHPs conditioned on the implementation of such a practice.

**Recommended Payment incentives for providers Language:**

The Department of Health and Human Services shall establish and maintain an official list of areas with critical provider shortages which could compromise health plan network adequacy. This list shall include health professional shortage areas, medically underserved areas, physician scarcity areas, mental health professional shortage areas and other areas with critical provider shortages as determined by the Department.



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If any item or service covered by a Qualified Health Plan is delivered by a provider who is not an essential community provider, and is delivered in an area defined as a critical provider shortage area, the QHP shall pay to that provider a supplemental amount equal to five percent of the generally applicable payment rates of the plan for that service.

Health Insurance Exchanges shall assure the existence of these supplemental payment provisions when certifying the network adequacy of each Qualified Health Plan.

**Conclusion**

The Patient Protection and Affordable Care Act providers us with an unprecedented opportunity to ensure that the vast majority of individuals residing in the United States have access to quality, affordable healthcare. It has been estimated that millions of individuals not currently insured will purchase health insurance through the Health Insurance Exchanges.

Unless the types of changes we recommended in these comments are adopted, we are fearful that the lofty goals of the PPACA will not be met as it relates to individuals residing in rural areas.

It cannot be stressed enough that simply providing someone with a health insurance card does not ensure that the individual has access to healthcare. If the provider to whom that person has reasonable access is not covered by a health plan or part of that plan's network, then the card is meaningless.

The value and utility of the insurance policy to the individual will be directly related to what services and providers are covered by the Qualified Health Plan. If the QHP does not cover the types of providers (CAH, RHC etc.) the individual has access to, or if its network does not include the nearby or essential providers the individual relies on, the policy is meaningless or worse.

NOSORH believes that all individuals residing in rural areas should have access to quality healthcare at an affordable price. We hope you share that goal and will make the types of changes we are recommending in order to assure that outcome.

Sincerely,

John Barnas
President

Teryl Eisinger
Director

Attachment



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# Medicare Advantage Network Adequacy Standards

| *Table 1:* **Minimum Provider Ratios*** | | | | | |
|---|---|---|---|---|---|
| **Specialty** | **Geographic Type** | | | | |
| | **Large Metro** | **Metro** | **Micro** | **Rural** | **CEAC** |
| General Practice (See Guidance) | | | | | |
| Family Practice (See Guidance) | | | | | |
| Internal Medicine (See Guidance) | | | | | |
| Geriatrics (See Guidance) | | | | | |
| Primary Care - Physician Assistants (See Guidance) | | | | | |
| Primary Care - Nurse Practitioners (See Guidance) | | | | | |
| Primary Care | 1.67 | 1.67 | 1.42 | 1.42 | 1.42 |
| Allergy and Immunology | 0.05 | 0.05 | 0.04 | 0.04 | 0.04 |
| Cardiology | 0.27 | 0.27 | 0.23 | 0.23 | 0.23 |
| Cardiac Surgery | 0.01 | 0.01 | 0.01 | 0.01 | 0.01 |
| Chiropractor | 0.10 | 0.10 | 0.09 | 0.09 | 0.09 |
| Dermatology | 0.16 | 0.16 | 0.14 | 0.14 | 0.14 |
| Endocrinology | 0.04 | 0.04 | 0.03 | 0.03 | 0.03 |
| ENT/Otolaryngology | 0.06 | 0.06 | 0.05 | 0.05 | 0.05 |
| Gastroenterology | 0.12 | 0.12 | 0.10 | 0.10 | 0.10 |
| General Surgery | 0.28 | 0.28 | 0.24 | 0.24 | 0.24 |
| Gynecology, OB/GYN | 0.04 | 0.04 | 0.03 | 0.03 | 0.03 |
| Infectious Diseases | 0.03 | 0.03 | 0.03 | 0.03 | 0.03 |
| Nephrology | 0.09 | 0.09 | 0.08 | 0.08 | 0.08 |
| Neurology | 0.12 | 0.12 | 0.10 | 0.10 | 0.10 |
| Neurosurgery | 0.01 | 0.01 | 0.01 | 0.01 | 0.01 |
| Oncology - Medical, Surgical | 0.19 | 0.19 | 0.16 | 0.16 | 0.16 |
| Oncology - Radiation/Raditation Oncology | 0.06 | 0.06 | 0.05 | 0.05 | 0.05 |
| Ophthalmology | 0.24 | 0.24 | 0.20 | 0.20 | 0.20 |
| Oral and Maxillofacial Surgery | 0.01 | 0.01 | 0.01 | 0.01 | 0.01 |
| Orthopedic Surgery | 0.20 | 0.20 | 0.17 | 0.17 | 0.17 |
| Physiatry, Rehabilitative Medicine | 0.04 | 0.04 | 0.03 | 0.03 | 0.03 |
| Plastic Surgery | 0.01 | 0.01 | 0.01 | 0.01 | 0.01 |
| Podiatry | 0.19 | 0.19 | 0.16 | 0.16 | 0.16 |
| Psychiatry | 0.14 | 0.14 | 0.12 | 0.12 | 0.12 |
| Pulmonology | 0.13 | 0.13 | 0.11 | 0.11 | 0.11 |
| Rheumatology | 0.07 | 0.07 | 0.06 | 0.06 | 0.06 |
| Thoracic Surgery | 0.01 | 0.01 | 0.01 | 0.01 | 0.01 |
| Urology | 0.12 | 0.12 | 0.10 | 0.10 | 0.10 |
| Vascular Surgery | 0.02 | 0.02 | 0.02 | 0.02 | 0.02 |

*Minimum number of providers required is based upon the (minimum provider to beneficiary ratio) multiplied by the (95th percentile of the average health plan market share times the total Medicare beneficiaries residing in a county)



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| *Table 2:* **Provider Time and Distance Requirements** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Specialty** | **Geographic Type** | | | | | | | | | |
| | **Large Metro** | | **Metro** | | **Micro** | | **Rural** | | **CEAC** | |
| | **Time** (minutes) | **Distance** (miles) | **Time** (minutes) | **Distance** (miles) | **Time** (minutes) | **Distance** (miles) | **Time** (minutes) | **Distance** (miles) | **Time** (minutes) | **Distance** (miles) |
| General Practice (See Guidance) | | | | | | | | | | |
| Family Practice (See Guidance) | | | | | | | | | | |
| Internal Medicine (See Guidance) | | | | | | | | | | |
| Geriatrics (See Guidance) | | | | | | | | | | |
| Primary Care - Physician Assistants (See Guidance) | | | | | | | | | | |
| Primary Care - Nurse Practitioners (See Guidance) | | | | | | | | | | |
| Primary Care | 25 | 5 | 25 | 10 | 30 | 20 | 45 | 30 | 75 | 60 |
| Allergy and Immunology | 35 | 15 | 45 | 30 | 70 | 60 | 85 | 75 | 120 | 110 |
| Cardiology | 25 | 5 | 30 | 20 | 45 | 35 | 75 | 60 | 90 | 85 |
| Cardiac Surgery | 40 | 15 | 60 | 40 | 85 | 75 | 100 | 90 | 140 | 130 |
| Chiropractor | 35 | 15 | 45 | 30 | 70 | 60 | 85 | 75 | 120 | 110 |
| Dermatology | 30 | 10 | 45 | 30 | 55 | 45 | 75 | 60 | 110 | 100 |
| Endocrinology | 40 | 15 | 60 | 40 | 85 | 75 | 100 | 90 | 140 | 130 |
| ENT/Otolaryngology | 35 | 15 | 45 | 30 | 70 | 60 | 85 | 75 | 120 | 110 |
| Gastroenterology | 30 | 10 | 45 | 30 | 55 | 45 | 75 | 60 | 110 | 100 |
| General Surgery | 25 | 5 | 30 | 20 | 45 | 35 | 75 | 60 | 90 | 85 |
| Gynecology, OB/GYN | 35 | 15 | 45 | 30 | 70 | 60 | 85 | 75 | 120 | 110 |
| Infectious Diseases | 40 | 15 | 60 | 40 | 85 | 75 | 100 | 90 | 140 | 130 |
| Nephrology | 35 | 15 | 45 | 30 | 70 | 60 | 85 | 75 | 120 | 110 |
| Neurology | 30 | 10 | 45 | 30 | 55 | 45 | 75 | 60 | 110 | 100 |
| Neurosurgery | 40 | 15 | 60 | 40 | 85 | 75 | 100 | 90 | 140 | 130 |
| Oncology - Medical, Surgical | 30 | 10 | 45 | 30 | 55 | 45 | 75 | 60 | 110 | 100 |
| Oncology - Radiation/Raditation ( | 40 | 15 | 60 | 40 | 85 | 75 | 100 | 90 | 140 | 130 |
| Ophthalmology | 25 | 5 | 30 | 20 | 45 | 35 | 75 | 60 | 90 | 85 |
| Oral and Maxillofacial Surgery | 40 | 15 | 60 | 40 | 85 | 75 | 100 | 90 | 140 | 130 |
| Orthopedic Surgery | 25 | 5 | 30 | 20 | 45 | 35 | 75 | 60 | 90 | 85 |
| Physiatry, Rehabilitative Medicine | 35 | 15 | 45 | 30 | 70 | 60 | 85 | 75 | 120 | 110 |
| Plastic Surgery | 40 | 15 | 60 | 40 | 85 | 75 | 100 | 90 | 140 | 130 |
| Podiatry | 30 | 10 | 45 | 30 | 55 | 45 | 75 | 60 | 110 | 100 |
| Psychiatry | 30 | 10 | 45 | 30 | 55 | 45 | 75 | 60 | 110 | 100 |
| Pulmonology | 30 | 10 | 45 | 30 | 55 | 45 | 75 | 60 | 110 | 100 |
| Rheumatology | 40 | 15 | 60 | 40 | 85 | 75 | 100 | 90 | 140 | 130 |
| Thoracic Surgery | 40 | 15 | 60 | 40 | 85 | 75 | 100 | 90 | 140 | 130 |
| Urology | 30 | 10 | 45 | 30 | 55 | 45 | 75 | 60 | 110 | 100 |
| Vascular Surgery | 40 | 15 | 60 | 40 | 85 | 75 | 100 | 90 | 140 | 130 |



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*Table 3:* Access Criteria for Facility Types

| Specialty | Geographic Type | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Large Metro | | | Metro | | | Micro | | | Rural | | | CEAC | | |
| | Number/ 1,000 | Minimum Time (minutes) | Minimum Distance (miles) | Number/ 1,000 | Minimum Time (minutes) | Minimum Distance (miles) | Number/ 1,000 | Minimum Time (minutes) | Minimum Distance (miles) | Number/ 1,000 | Minimum Time (minutes) | Minimum Distance (miles) | Number/ 1,000 | Minimum Time (minutes) | Minimum Distance (miles) |
| Acute Inpatient Hospitals | 12.2 | 20 | 10 | 12.2 | 45 | 30 | 12.2 | 75 | 60 | 12.2 | 75 | 60 | 12.2 | 110 | 100 |
| Cardiac Surgery Program | NA | 20 | 10 | NA | 45 | 30 | NA | 145 | 120 | NA | 145 | 120 | NA | 165 | 140 |
| Cardiac Catheterization Services | NA | 20 | 10 | NA | 45 | 30 | NA | 145 | 120 | NA | 145 | 120 | NA | 165 | 140 |
| Critical Care Services – Intensive Care Units (ICU) | NA | 20 | 10 | NA | 45 | 30 | NA | 145 | 120 | NA | 145 | 120 | NA | 165 | 140 |
| Outpatient Dialysis | NA | 20 | 10 | NA | 45 | 30 | NA | 145 | 120 | NA | 145 | 120 | NA | 165 | 140 |
| Surgical Services (Outpatient or ASC) | NA | 20 | 10 | NA | 45 | 30 | NA | 75 | 60 | NA | 75 | 60 | NA | 110 | 100 |
| Skilled Nursing Facilities | NA | 20 | 10 | NA | 45 | 30 | NA | 75 | 60 | NA | 75 | 60 | NA | 90 | 85 |
| Diagnostic Radiology | NA | 20 | 10 | NA | 45 | 30 | NA | 75 | 60 | NA | 75 | 60 | NA | 110 | 100 |
| Mammography | NA | 20 | 10 | NA | 45 | 30 | NA | 75 | 60 | NA | 75 | 60 | NA | 110 | 100 |
| Physical Therapy | NA | 20 | 10 | NA | 45 | 30 | NA | 75 | 60 | NA | 75 | 60 | NA | 110 | 100 |
| Occupational Therapy | NA | 20 | 10 | NA | 45 | 30 | NA | 75 | 60 | NA | 75 | 60 | NA | 110 | 100 |
| Speech Therapy | NA | 20 | 10 | NA | 45 | 30 | NA | 75 | 60 | NA | 75 | 60 | NA | 110 | 100 |
| Inpatient Psychiatric Facility Services | NA | 20 | 10 | NA | 65 | 45 | NA | 90 | 75 | NA | 90 | 75 | NA | 165 | 140 |
| Orthotics and Prosthetics | NA | 20 | 10 | NA | 45 | 30 | NA | 145 | 120 | NA | 145 | 120 | NA | 165 | 140 |
| Home Health (See Guidance) | NA | | | NA | | | NA | | | NA | | | NA | | |
| Durable Medical Equipment (See Guidance) | NA | | | NA | | | NA | | | NA | | | NA | | |
| Outpatient Infusion/Chemotherapy | NA | 30 | 10 | NA | 45 | 30 | NA | 75 | 60 | NA | 75 | 60 | NA | 110 | 100 |
| Laboratory Services | NA | 25 | 5 | NA | 25 | 10 | NA | 75 | 60 | NA | 75 | 60 | NA | 110 | 100 |
| Heart Transplant Program (See Guidance) | NA | | | NA | | | NA | | | NA | | | NA | | |
| Heart/Lung Transplant (See Guidance) | NA | | | NA | | | NA | | | NA | | | NA | | |
| Intestinal Transplant Program (See Guidance) | NA | | | NA | | | NA | | | NA | | | NA | | |
| Kidney Transplant Program (See Guidance) | NA | | | NA | | | NA | | | NA | | | NA | | |
| Liver Transplant Program (See Guidance) | NA | | | NA | | | NA | | | NA | | | NA | | |
| Lung Transplant Program (See Guidance) | NA | | | NA | | | NA | | | NA | | | NA | | |
| Pancreas Transplant Program (See Guidance) | NA | | | NA | | | NA | | | NA | | | NA | | |



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