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Display PARHM Claim Payment Amounts

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Related Change Request (CR) Number: 11355
Related CR Release Date: November 4, 2019
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Implementation Date: January 6, 2020

Note: We revised this article on November 5, 2019, to reflect the revised CR11355 issued on November 4. The Background Section of the CR was revised. The last sentence of the first paragraph of the Background Section of this article reflects the revised CR language. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for hospitals participating in the Pennsylvania Rural Health Model (PARHM) and billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR11355 announces creation of a protected line level field to house the line level payment amount for the PARHM. This field will represent the actual amount Medicare paid for the line. Make sure your billing staffs are aware of these changes.

BACKGROUND

The Pennsylvania Rural Health Model changes Medicare reimbursement for hospital participants in the following way: rather than typical Fee-for-Service (FFS) claims reimbursement for certain services, Medicare makes every-other-week, lump sum payments to participating hospitals for those services. Each of these payments is equal to 1/26 of the Medicare global budget amount, which is set prospectively with the potential for adjustments during the year. The Centers for Medicare & Medicaid Services (CMS) is using the Periodic Interim Payment (PIP) process to make these biweekly payments. The participating hospitals continue to submit claims to CMS as usual, but CMS does not make FFS reimbursement on services that are included in the global budget. This means that all claims are included in the global budget and are treated as zero-pay; and pass through payments paid outside of claims, such as Direct Graduate Medical Education (DGME), organ acquisition, bad debt, etc. are non-global services and continue to be paid outside of the global budget.

CMS records the “net reimbursement amount” as the amount that would have been paid in the absence of the global budgets. For example, if a claim from a participating hospital only includes

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global budget services, the “net reimbursement amount” does not display $0 (the amount actually paid by CMS on that claim)—instead it records whatever amount Medicare would have reimbursed the hospital in the absence of the model. The biweekly Periodic Interim Payments (PIPs) also display reimbursement amounts.

ADDITIONAL INFORMATION

The official instruction, CR11355, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R233DEMO.pdf.

You may find information about the PARHM at https://innovation.cms.gov/initiatives/pa-rural-health-model/.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

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November 5, 2019	We revised this article to reflect the revised CR11355 issued on November 4. The Background Section of the CR was revised. The last sentence of the first paragraph of the Background Section of this article reflects the revised CR language. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.
August 9, 2019	Initial article released.