



Related MLN Matters Article #: SE0734

Date Posted: August 15, 2007

Related CR #: N/A

Limitation on Charges for Services Furnished by Medicare Participating Hospitals to Individuals Eligible for Care through Indian Health Service (IHS) Programs

Key Words

SE0734, Indian, IHS, Hospital, SNF

Provider Types Affected

Medicare participating hospitals and skilled nursing facilities (SNFs) servicing individuals eligible for care through IHS health programs

Key Points

- Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires hospitals that furnish any Medicare payable inpatient hospital medical care services to participate in both:
 - The contract health services (CHS) program of the IHS operated by the IHS, Tribes, and Tribal organizations; and
 - IHS-funded programs operated by urban Indian organizations. All of these programs are collectively referred to as Indian Health Service, Tribal, and Urban Indian (I/T/U) Programs, for any care that these programs purchase.
- For purposes of this program, a hospital is defined as all hospitals that participate in Medicare, including any hospital clinics located off-site and critical access hospitals (CAHs), to include:
 - Acute care hospitals,
 - Distinct parts of inpatient hospitals (rehabilitation facilities, psychiatric facilities),
 - Hospital-based clinics,
 - Psychiatric hospitals,
 - Rehabilitation hospitals,
 - Long-term care hospitals,
 - CAHs (including rehabilitation and psychiatric units paid under a prospective payment system (PPS) located within),

- Children's hospitals,
- Cancer hospitals, and
- SNFs and swing beds.
- Section 506 also requires such participation to be in accordance with the admission practices, payment methodology, and payment rates set forth in Department of Health and Human Services regulations, including accepting these payment rates as payment in full.
- Effective July 5, 2007, all Medicare participating hospitals that furnish inpatient services must accept no more than the rates of payment under the calculation described below as payment in full for all items and services authorized by I/T/U organization entities.
- This payment methodology applies to all levels of care furnished by a Medicare participating hospital that is authorized by:
 - A CHS program of the IHS, or
 - Authorized by a Tribe or Tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act, or that an urban Indian program authorizes for purchase.
- This includes care provided as inpatient, outpatient, or SNF care, as well as other services of a department, subunit, distinct part, or other hospital component (including services the hospital furnishes directly or under arrangements).

Basic Payment Determination/Methodology

Prospective Payment System

- Under this new rule, the basic payment determination for hospital services that Medicare would pay for under a PPS is based on that particular PPS.
- For example, inpatient hospital services of acute care hospitals, psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals will be paid based on the same PPS systems Medicare uses to pay for similar hospital services under 42 Code of Federal Regulations, Part 412.
- Similarly, outpatient hospital services and SNF care will be paid based on the PPS systems that Medicare uses to pay for those services under 42 CFR Part 419 and 42 CFR Part 413, respectively.

Reasonable Costs

- Medicare participating hospitals that furnish inpatient services, but are exempt from inpatient PPS and receive reimbursement based on reasonable costs (for example, CAHs, children's hospitals, cancer hospitals, and certain other hospitals reimbursed by Medicare under special arrangements), will be paid per discharge based on the reasonable cost methods established under 42 CFR Part 413 (except that the interim payment rate under 42 CFR Part 413, Subpart E constitutes payment in full for authorized charges).

Coinsurance

- CHS programs will continue to pay the equivalent of Medicare coinsurance.
- The I/T/Us' payment calculations will be based on these determinations consistent with the Centers for Medicare & Medicaid Services' (CMS') instructions to fiscal intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) at the time the claim is processed.
- For inpatient services, I/T/Us will pay a providing hospital the full PPS-based rate (or the interim reasonable cost rate) without reduction for any co-payments, coinsurance, and deductibles that the Medicare program requires patients to contribute.
- For outpatient, or Part B services, IHS/CHS will pay both the Medicare and beneficiary's portion of the payment. In either instance, the hospital will get 100% of whatever the Medicare rate is for the service provided.
- If the I/T/U has negotiated a payment amount with a hospital or its agent, the I/T/U will pay the lesser of the negotiated amount, or the amount determined from Basic Payment Determination (above) (including, but not limited to, capitated contracts or contracts per federal law requirements).
- Providers should be aware that in addition to the amount payable for authorized inpatient services (described above), payments will also include an amount to cover (to the extent such costs would be payable if the services had been covered by Medicare) the following:
 - The organ acquisition costs that hospitals with approved transplantation centers incur;
 - Direct medical education costs;
 - Units of blood clotting factor furnished to an eligible hemophiliac patient; and
 - The costs of qualified non-physician anesthetists.
- These payments will be made on a per discharge basis and will be based on standard payments that CMS or its FIs or A/B MACs establish.

Important Details about the Program

- If an I/T/U has authorized payment for items and services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payer, the I/T/U:
 - Will be the payer of last resort;
 - Will pay the amount that the patient is responsible for (after the provider of services has coordinated benefits and all other alternative resources have been considered and paid), including applicable co-payments, deductibles, and coinsurance that the patient owes;
 - Will pay only that portion of the payment amount not covered by any other payer;
 - Will make no payment that exceeds the rate calculated in the Basic Payment Determination/Methodology section (above) or the contracted amount (plus applicable cost sharing), whichever is less; and
 - Will make no additional payment to that made by Medicaid (except for applicable cost sharing) because Medicaid payment is considered payment in full.

Note: Payments made for these services are considered payment in full, and a hospital or its agent may not impose any additional charge on the patient for any I/T/U authorized items and services, or for information that the I/T/U, its agent, or the FI (A/B MAC) request to determine payment or for quality assurance use.

- If it is determined that a hospital has submitted inaccurate information for payment (such as admission, discharge, or billing data), an I/T/U may (as appropriate):
 - Deny payment for these services (in whole or in part), and
 - Disallow costs previously paid.
- If for cost-based payments previously issued, it is determined that actual costs fall significantly below the computed rate actually paid, the computed rate may be retrospectively adjusted.
- The recovery of overpayments made as a result of the adjusted rate, or of payments made in error may be accomplished by any method authorized by law.
- For a hospital (or its agent) to be eligible for payment from Indian health programs, it must submit the claim for authorized services as follows:
 - On a UB-04 paper claim form or the Health Insurance Portability and Accountability Act 837 electronic claim format American National Standards Institute X12N, Version 4010A1 and include the hospital's Medicare Online Survey Certification and Reporting System number/National Provider Identifier;
 - To the I/T/U, agent, or FI (A/B MAC) the I/T/U identifies in the agreement with the hospital or in the authorization for services I/T/U provides; and
 - Within a time period equivalent to the timely filing period for Medicare claims under 42 CFR 424.44 and provisions of the *Medicare Claims Processing Manual* applicable to the type of item or service provided.
- Participating hospitals and CAHs must accept the payment methodology and no more than the rates of payment (explained above), as payment in full for the following programs:
 - A CHS program of the IHS;
 - A CHS program carried out by an Indian Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act; and
 - A program funded through a grant or contract by the IHS and operated by an urban Indian organization, under which items and services are purchased for an eligible urban Indian.
- Hospitals and CAHs **may not** refuse service to an individual on the basis that the payment for such service is authorized under such CHS and IHS-funded urban Indian programs.
- The following facilities or services are **not** covered by this regulation.
 - Free standing ambulatory surgery centers,
 - Surgical centers,
 - Physician services,

- Services of independent practitioners (nurse practitioners, physician assistants, clinical nurse specialists, etc),
- Independent laboratories,
- Any service or supply not covered by the Medicare program,
- Services of a renal dialysis facility,
- Home health services, and
- Hospice services.
- Providers need to remember:
 - Inpatient PPS hospitals are paid based on discharge date. Therefore, if a patient were discharged on July 5, 2007, the entire stay would be paid under the applicable PPS.
 - CAHs' and Tax Equity & Fiscal Responsibility Act of 1982 hospitals' inpatient services will be paid based on whether the actual date of service falls on or after July 5, 2007. Line item dates of service can apply to the Outpatient PPS and other Part B outpatient claims.
 - Payment for outpatient services is based on the date of service.

Treating Patients with Serious Health Issues

- IHS payment under this rule will reflect serious health issues faced by its patient population, as patients who are more seriously ill tend to require a higher level of hospital resources than patients who are less seriously ill, even though they may be admitted to the hospital for the same reason.
- Recognizing this, Medicare payments can be higher for patients in certain diagnostic-related groups based on a secondary diagnosis that could indicate specific complications or co-morbidities.
- While these rates are generally not available to non-Indians who are members of an eligible Indian's household, if the individual meets the requirements at 42 CFR Part 136 for CHS coverage (e.g., non-Indian woman pregnant with eligible Indian's child, public health emergency), and payment is authorized by the CHS program (or by an Urban Indian program), then the Medicare-like rates do apply.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0734.pdf> on the CMS website.

Providers can find more information about the limitation on charges for services furnished by Medicare participating inpatient hospitals to individuals eligible for care through Indian Health Programs by reading the Federal Register at <http://www.nrepp.samhsa.gov/pdfs/FRN060407.pdf> on the CMS website.

If providers have any questions, they may contact their CMS Regional Office. Contact information for those offices is available at <http://www.cms.hhs.gov/RegionalOffices/> on the CMS website.