

**MEDICARE-LIKE RATES
for CHS SERVICES
FAQ
September 19, 2007**

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MEDICARE-LIKE RATES for CHS SERVICES FAQ

GENERAL

- 1. If a hospital does not comply with the law and continue to bill at the usual rates, where does the facility go to report this?**

The facilities are supposed to bill at their usual rates. There is nothing to be reported. It is the payment that will be at Medicare-Like-Rates. Should a facility not comply with the law to accept MLR as payment, the facility should report this to the area CHSO, who will notify the Regional Native American Contact (NAC). CMS has regional offices that oversee CMS activities in all states and included are responsibilities for IHS and tribal programs.

- 2. Can we obtain a list of CHS vendors that are not a Medicare participating hospital from the FI to share with our Acquisition staff so they can continue to negotiate on behalf of the Areas with those that are not included in this new ruling.**

The IHS/CHS FI does not know which hospitals are Medicare participating. If we need the FI to identify these providers we can do that.

- 3. Has the Dear Tribal Leader letter gone out?**

Yes - the Dear Tribal Leader letter went out.

- 4. What should I do if I receive a claim with only a National Provider Identifier (NPI) and/or Tax ID? In other words, I do not have an OSCAR provider number on the claim?**

You may either contact the hospital to find their OSCAR Number, or you may obtain the OSCAR from the "CMS Listing" Provider File on the following website:

<http://www.ihs.gov/Cio/RPMS/index.cfm?module=home&option=otherdocuments>. The listing provides you with a hospital's name, address, OSCAR #, etc.

- 5. Where can I find information in regards to what all of the patient status codes mean?**

Go to the Medicare Claims Processing Manual (Pub. 100-04), Chapter 25 for definitions of all Medicare claim elements: <http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf>

- 6. How/who is to notify hospitals that they are to bill IHS at Medicare-like rates?**

It is important to make the following distinction. Hospitals will bill as they normally would for all payers. Hospitals must understand that they will be **reimbursed** at MLR. CMS/Medicare has issued a MedLearn article describing this legislation to Medicare participating providers.

7. Is the letter notifying hospitals of the Medicare-like rate billing to go out before IHS starts paying these rates?

Yes, facilities need to be notified before the new billing rate goes into effect. A sample provider letter is linked to the WEB site. CMS/Medicare has also issued a MedLearn article to Medicare providers describing this legislation.

8. Will there be training on how to read a claim from a hospital?

This will be taken under advisement.

CONTRACT HEALTH SERVICES (CHS)

9. May the tribal or urban program set its own policies regarding CHS?

No, the program must comply with the regulations (42 CFR Part 136). The program may develop its own policies for areas that are not addressed in the regulation (e.g. setting Levels of Care funded by the CHS program).

10. We use Third Party funds to pay costs for certain members who do not qualify for CHS funding. Do the Medicare-like rates apply for these services?

No. Medicare-like rates only apply for services payable through the CHS program, for individuals who are eligible for CHS coverage, as defined by 42 CFR Part 136.

11. We use Third Party funds to add to our CHS funds. Do Medicare-like rates apply for these services?

Yes, as long as the CHS pays for the services and follows the regulations that apply to CHS and client eligibility (42 CFR Part 136).

12. Are patients that have no insurance and are not CHS eligible to be paid at the Medicare-like Rate?

No

13. What happens when a tribally managed program has determined to only pay for Tribal members and an eligible Native living in their CHSDA that is not a member of that Tribe is referred for contract health services to a participating hospital?

MLR applies as long as the eligible non-tribal member has his care paid for by a CHS program.

14. Can Tribes that do not follow the Indian Health CHS regulations use Medicare-like Rates?

No, the program must comply with the regulations (42 CFR Part 136). The program may develop its own policies for areas that are not addressed in the regulation (e.g. setting Levels of Care funded by the CHS program).

15. Are foster children covered by Medicare-like Rates?

Yes, as long as they remain eligible for CHS and payment is authorized by the CHS program (or by an Urban program).

16. Are Tribes that serve Tribal members only covered by the Medicare-like Rates regulations?

Yes, as long as they are authorized under the CHS program.

17. If a Tribe pays for patients out side of its CHSDA with Tribal funds can they pay using Medicare-like Rates?

Yes, as long as they meet CHS eligibility requirements within the regulations and services are authorized by the CHS program.

18. Are the rates available to non-Indians who are members of an eligible Indian's household?

Normally, no. However, 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 program), then the Medicare-like rates do apply.

REGULATION

20. When does the MLR regulation become effective?

July 5, 2007

21. What facilities are covered by this regulation?

All hospitals that participate in Medicare, including any hospital clinics located off-site and Critical Access Hospitals. "Hospitals" may include:

- Acute care hospitals
- Distinct parts of inpatient hospitals (rehabilitation facilities, psychiatric facilities)
- Hospital based clinics
- Psychiatric Hospitals
- Rehabilitation hospitals
- Long Term Care Hospitals
- Critical Access Hospitals (including rehab and psych units paid under PPS located within)
- Children's Hospitals
- Cancer Hospitals
- SNFs & Swing Beds

22. What facilities or services are NOT covered by this regulation?

- Free standing ambulatory surgery centers (ASC's)
- 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
- Home Health
- Hospice Services

23. Are services furnished in a hospital-based clinics/unit covered under MLR?

Facility/Hospital services (inpatient and outpatient), are covered. If the clinic/unit is billing under the hospital's Medicare provider number (i.e., OSCAR), the services are covered under the MLR if the services were billed on a 13x or 85x Type of Bill (TOB). Professional services are never covered under MLR.

24. The diagnostic procedure is under MLR so is the physician fee in this?

Physician services are not reimbursed under MLR.

25. Are emergency room services covered under Medicare-like Rates?

Yes, the facility's ER services are covered under the MLR. The physician's services in the ER are NOT covered under the MLR.

26. Is a surgery clinic in a participating hospital covered by Medicare-like Rates?

Yes, if the clinic is located within a Medicare participating hospital.

27. If the hospital is a participating hospital and there are physician services, is the physician fees paid at Medicare-like rates?

Physician services are not reimbursed under MLR.

PAYMENT

28. Does my local hospital have to accept these rates?

Yes, if the local hospital is a Medicare participating hospital, and if your CHS program has authorized payment for the services.

29. What services are payable at Medicare-like rates?

Any service or supply for which Medicare would otherwise pay under an inpatient PPS rate, hospital outpatient PPS (known as OPPS) rate, or cost-based reimbursement rate when paid to a hospital that is also an inpatient hospital, as defined by the regulation. In addition, the service or supply must be provided to a CHS eligible individual and paid by an IHS or tribal CHS program or by an Urban Indian program.

30. For inpatient services, does "date of service" mean the admission date, or the individual date of service? If a patient is admitted to a Medicare-participating hospital on July 2, 2007

and discharged on July 10, 2007, does the Medicare-like rates apply to all charges incurred on or after July 5, 2007, or only for admissions occurring on or after July 5, 2007?

The rule applies to those charges incurred on or after the individual “Date of service” for outpatient.

PPS hospitals are paid based on discharge date and the entire stay would be covered in the example above. If the patient is discharged after 7/5/07, then the entire bill would be paid under the applicable PPS.

For CAHs and TEFRA 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 OPSS and other Part B outpatient claims.

31. How do hospitals bill us for services?

Hospitals must bill using the UB-04 format for paper claims or the HIPAA 837i standard for electronic claims format (ANSI X23N) if the tribal/urban program can accept electronic transactions. The hospital is required to bill under its NPI. The Medicare OSCAR number may or may not be present on the claim form.

32. If the patient is referred to the outpatient department of a hospital for a diagnostic test (e.g., CT scan), is this covered under MLR? How do ER visits fit into the MLR policy?

If the hospital is billing for this service, MLR covers the technical component(s) only. The professional component(s) are not covered under the MLR.

33. Under the Inpatient Prospective Payment System (IPPS), does each hospital have its own outlier threshold?

Yes. The outlier threshold amount is specific to each hospital and is maintained within the Pricer software.

34. What is the UB-04 claim form? I am used to receiving UB-92 claims.

The UB-04 is a new claim form as established by the National Uniform Billing Committee. The prior claim form—known as the UB-92—expired in May, 2007. Hospitals should be submitting claims to you on the UB-04. If a hospital continues to bill under the expired UB-92, your organization will have to determine whether you will still accept the UB-92 claim(s) or you will have to tell the hospital to re-submit using the UB-04.

35. How is the add-on for the DSH payment determined?

THE IPPS PC PRICER WILL CALCULATE THE DSH PAYMENT FOR YOU. The DSH payment is included in the ‘Final PPS Payment’ (as determined by Pricer) on hospitals where DSH is applicable. You DO NOT have to manually determine this calculation.

For a detailed discussion of DSH policy, please refer to Section 20.3 of the link to the Medicare manual below:

<http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf>

36. Do I need a DRG Grouper to know what the DRG will be?

On UB-04s, there is a space for the DRG in Form Locator (FL) 71—“PPS Code.” However, FL 71 is not a required field so there may not be a DRG in that field. To determine the DRG, or to verify that a hospital’s DRG is correct (as submitted in FL 71), you will want to obtain a Grouper program. To do this, you can go to the www.drg.irp.com website to enter the ICD-9 procedure and diagnosis codes, in order to assign the correct DRG. You may also obtain DRG-pricing software (which includes a Grouper program) from a vendor/contractor.

37. How does Tribal insurance play into Medicare-like rate payments?

Your program pays the lesser of the difference between what Medicare would pay (the Medicare-like rate) and what tribal the insurance paid or the patient balance after the tribal insurance paid.

38. Where do we find listings of the MLR percentage that the critical access hospitals are allowed by Medicare to be paid?

Each State has a Medicare Fiscal Intermediary or Medicare contractor that has responsibility to manage the health care needs of the Medicare population. Included in these activities are notices/reports to critical access hospitals of the interim rate for reimbursement which is a percentage of their billed charges for outpatient services. It may also be a per diem amount for inpatient services. Therefore, the answer to the question is to contact the Medicare Fiscal Intermediary or contractor and request a copy of this report. The other contact may be the provider themselves because the report is provided to them routinely. A listing of Medicare contractors can be found at:

http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02_ICdirectory.pdf

39. A primary insurer pays more than the Medicare-like rate. As an IHS, what am I responsible for paying the hospital?

You are only responsible for services covered under the MLR policy. However, as payer of last resort, you are not responsible for any payment if another insurer already covered up to, or exceeding, what Medicare would have paid (the MLR). On the other hand, if another insurer covered less than the MLR, you would be responsible for the remaining balance—the difference between what Medicare would have paid and what the other insurer(s) paid.

40. What patients are eligible for these rates?

Any patient for whom payment is authorized by the IHS or tribal health program’s CHS program (as defined by IHCIA & under 42 CFR part 136), or authorized for purchase under 42 CFR 136.31 by an urban Indian organization

I/T/Us must comply with federal regulation regarding CHS, as published at 42 CFR part 136.

41. Is the rate available to our patients?

No, the Medicare-like rates are available only to I/T/U facilities for the patients for whom the facility authorizes payment to the hospital.

42. Is the rate available to tribes that pay for health care services for their members?

The rate is only available to programs, which may include tribes that have an IHS 638 contract and authorize payment of the service through their CHS program.

43. Who computes the amount of payment due to the hospital?

The Medicare-participating hospital you've referred patients to through your CHS program will bill you its normal charges. Your facility is responsible for computing and verifying the Medicare-like rate for all services, including any additional payments due to the hospital. These additional payments include costs for disproportionate share hospitals, direct medical education, organ acquisition costs at approved transplantation centers, units of blood clotting factor for hemophiliacs, and the costs of qualified non-physician anesthetists.

44. What rates do I/T/U's pay for CHS covered services under the final MLR rule?

- a) Acute Care Hospital, Long Term Care Hospital, Inpatient Rehabilitation Facility, and Inpatient Psychiatric Facility's inpatient services, SNF and Swing Bed are paid at the Medicare PPS allowable rate, plus any applicable co-payment, deductible, coinsurance amounts that the patient would otherwise be required to pay.
- b) Hospitals exempt from PPS (CAHs, children's hospitals, cancer hospitals) – Medicare interim rate for reasonable cost based reimbursement.
- c) Hospital Outpatient Departments (e.g. hospital outpatient services) - Medicare outpatient PPS rate.
 - In addition to the above, the I/T/U would pay any additional fees for
 - Direct medical education
 - Organ acquisition costs (approved transplantation centers);
 - Units of blood clotting factor (hemophiliacs)
 - Costs of qualified non-physician anesthetists.

Note that the web-based Pricer will calculate the pass-through for you. Blood clotting factor will have to be paid in addition.

45. How do we compute the rates?

Inpatient Hospital and SNF PPS Claims:

- CMS has free PC Pricer software that can be downloaded from its website (<http://www.cms.hhs.gov/PCPricer/>).
- Purchase Pricer software from commercial vendor.
- Contract with IHS/CHS Fiscal Intermediary
- Contract with local Medicare Fiscal Intermediary
- Contract with other vendor

Outpatient Claims (OPPS)

- Purchase Pricer software from commercial vendor
- Contract with IHS/CHS Fiscal Intermediary
- Contract with local Medicare Fiscal Intermediary
- Contract with other vendor

Inpatient Cost Based Reimbursement Claims

- Users will need to obtain the “rate” from the Medicare contractor and price the claim applying the Medicare cost-to-charge ratio to billed charges.
- Contract with IHS/CHS Fiscal Intermediary
- Contract with local Medicare Fiscal Intermediary
- Contract with other vendor

46. Can we put a cap on the reimbursement we pay to the hospital?

No. Your program must pay the full cost of the service or hospitalization – or the lesser of the patient portion of the bill after another insurance has paid OR the amount remaining after subtracting the insurance payment from the Medicare-like rate.

47. My program has contracted with the local hospital at a lower cost than the Medicare-like rate. Do I have to pay the higher rate?

No. The regulation allows your contract to continue and for your program to pay the lesser of the contract amount or the Medicare-like rate.

48. At what rate do you pay for a non-CHS eligible person?

CHS does not cover non eligible patients/families.

49. Once we download a PC Pricer, will the quarterly updates occur within my PC Pricer file automatically?

No, you will have to download the updated PC Pricer every quarter.

50. How often should I download the PC Pricer off of the PC Pricer website?

CMS updates the PC Pricer quarterly (Jan., April, July, Oct.) to include the most recent provider data and to include any calculation modifications. These quarterly updates do not occur until roughly a month into the start of the quarter. This month-delay allows the Medicare FIs time to submit all of the up-to-date provider information into CMS so that CMS can then load the provider data into the PC Pricer.

51. What should I do with an “old” PC Pricer download?

When a “new” PC Pricer is added to the PC Pricer website, any prior version of the software you had for the FY version becomes obsolete.

52. To enter PC Pricer inputs, how do I know where to look on the claim (UB-04) to find the necessary Pricer elements?

CMS offers a PC Pricer Manual on the PC Pricer page: <http://www.cms.hhs.gov/PCPricer/>

53. Can PRICER be used to get a cost estimate by putting in the discharge date?

Yes.

54. Do you need the hospital number to get pricing information from PRICER?

With the advent of the NPI, or National Provider Identifier, most Medicare providers now have 2 provider IDs: the NPI and the old Medicare provider ID, the OSCAR number. You must enter the OSCAR number so the Pricer can retrieve the data applicable to the particular provider. You must contact the facility and ask them for it.

55. Is PRICER the total amount or does it include the co-pay and deductible?

The PRICER total does not include co-payments and deductibles. Any applicable coinsurance amounts will need to be separately calculated.

56. Since there is no OPSS software available from CMS, how does CMS determine OPSS charges?

The CMS has the OPSS software on their mainframe. It is too complex to be made available in a package that can be down loaded to a PC.

57. What are the basic requirements for down loading PRICER?

The information can be obtained from the CMS PRICER WEB site.
[CMS PRICER Software](#)

CO-PAYS & DEDUCTIBLES

58. Are CHS programs going to continue to pay co-pays and deductibles? Or are you saying that what ever the providers get paid under the new regulation through the FI is all they will get; without the deductible or co-pays? I read also that you indicated whatever provider gets paid is considered payment in full?

Yes, CHS programs will continue to pay the equivalent of Medicare coinsurance. Under usual Medicare rules, Medicare will only pay the 80% and the beneficiary pays the 20% for outpatient services. With regard to AI/ANs the IHS pays the 20% on behalf of the beneficiary. For the MLR - Hospitals will bill the CHS program what they bill Medicare, or any other payer. The hospital will get 100% (usually 80%+20%) of whatever the Medicare rate is for the service provided.

Deductible will not apply for inpatient or outpatient services. For inpatient services there will be no coinsurance calculated. If you are calculating the outpatient payment using an OPSS Pricer, you will need to add the coinsurance amount to the reimbursement amount and pay the sum to the hospital.

Note: *While there is some variation in coinsurance percentage, the principle remains that the contracting entity (tribe, urban Indian program, IHS/CHS) will pay both the "Medicare portion" and the "beneficiary's". "This arrangement only applies to outpatient, or Part B, services."*

2007 Medicare Like Rates – Co-Pay Chart

Service	Deductible	Co-Pay	Full Medicare Payment – Amount IHS Pays
Hospital Outpatient	Does Not Apply	<p>(a) If you use an OPPS pricing program, the program deducts the Medicare co-pay from the amount Medicare reimburses as shown by the program.</p> <p>(b) If you receive services from a CAH or other non-OPPS provider, the co-pay would usually be 20% of the amount due.</p>	<p>You must find the amount that the pricing program subtracted as the co-pay and add it back in to the OPPS reimbursement amount to reach the full Medicare-Like Rate.</p> <p>You pay the amount of the cost to charge ratio multiplied by the charges amount. The 20% which is normally the co-pay is then included in this amount.</p>
Hospital Inpatient	Does not apply	Does not apply	The co-pay is included in the full amount as shown by the IPPS Pricer or in the case of a CAH, the full amount as calculated by the payment formula.
Skilled Nursing Facility	Does not apply	Does not apply	The copay is included and you pay the full amount as shown by the SNF Pricer

59. What do we pay if the patient has private insurance that pays a portion of the bill?

Your program pays the lesser of the difference between what Medicare would pay (the Medicare-like rate) and what the insurance company paid OR the patient balance after the insurance company paid, whichever is less.

60. Is the I/T/U still payor of last resort?

Yes.

61. What is the relationship between payments and deductibles? Do they apply to the pricing information?

There is no relationship between payments and any “Medicare” deductible. Deductibles do not apply to the pricing information.