CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 233	**Date: November 4, 2019**
	Change Request 11355

Transmittal 228, dated August 9, 2019, is being rescinded and replaced by Transmittal 233, dated, November 4, 2019 to add the MCS maintainer as a responsible party to business requirement 11355.4 and to revise the background section. All other information remains the same.

SUBJECT: Display PARHM Claim Payment Amounts

I. SUMMARY OF CHANGES: For Medicare Periodic Interim Payments (PIPs), the net reimbursement field on the claim is recorded is the amount that CMS would typically pay for the claim in the absence of the model, not the actual amount paid (which would be $0 in most cases). The Pennsylvania Rural Health Model (PARHM) team needs to be able to verify the actual amount paid on the claim. We are requesting that a special field be created to record the actual claim amount be at the line level and at the claim level.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Demonstrations

Attachment - Demonstrations

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I. GENERAL INFORMATION

A. 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. 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 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 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 PIP payments also display reimbursement amounts.

B. Policy: There is no new policy associated with this change request.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11355.1	The Medicare contractor shall create a protected line level field to house the line level payment amount for the PA Model. This field should be the standard size with a general name for future use. NOTE: This field will represent the actual amount Medicare paid for the line.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11355.2	The Medicare contractor shall create a protected claim level field to house the payment amount for the PA Model. This field should be the standard size with a general name for future use. NOTE: This field will represent the actual amount Medicare paid for the claim.					X				
11355.3	The Medicare Contractor shall send the claim and line level values for the PARHM Claim Payment Amounts fields to CWF.					X				
11355.4	The Medicare contractor shall accept the new added fields and pass the additional fields to the downstream systems. NOTE: Changes to HIMR for Instructional Part A claims in history shall also carry the new field.						X		X	FPS, IDR, NCH, PS&R

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11355.5	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Brede Eschliman, 719-650-8430 or brede.eschliman@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0