Referral and Payment Examples for American Indians and Alaska Natives[1]

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Example	Scenario	Referral and Payment	
		If patient has <u>zero</u> cost sharing plan	**If patient has <u>limited</u> cost sharing plan**
1	AI/AN goes to an <u>in-network I/T/U provider</u> for a **primary care visit.**	No plan referral or CHS referral is needed. Pt pays no cost sharing for EHB. Plan pays provider the contracted amount with no deduction for patient cost sharing.	No plan referral or CHS referral is needed. Pt pays no cost sharing for EHB. Plan pays provider the contracted amount with no deduction for patient cost sharing.
2	AI/AN goes to an <u>out-of-network I/T/U provider</u> for a **primary care visit.**	No plan referral or CHS referral is needed. • Plan may set a rate for out-of network cost sharing, but patient is exempt from paying the cost sharing for EHB. Plan pays provider the amount it would pay to other out-of network primary care providers and may not deduct any cost sharing. • If the plan rules state that there is no payment for out-of-network providers without a plan referral, then the I/T/U can still bill the plan for the service provided under Sec. 206 of IHCIA and the plan must pay the amount without deducting cost-sharing that would otherwise be charged to the patient.	No plan referral or CHS referral is needed. • Plan may set a rate for out-of network cost sharing, but patient is exempt from paying the cost sharing for EHB. Plan pays provider the amount it would pay to other out-of network primary care providers and may not deduct any cost sharing. • If the plan rules state that there is no payment for out-of-network providers without a plan referral, then the I/T/U can still bill the plan for the service provided under Sec. 206 of IHCIA and the plan must pay the amount without deducting cost-sharing that would otherwise be charged to the patient.

[1] These examples were prepared by the Tribal Technical Advisory Group ACA Policy Subcommittee with technical assistance from the Centers for Medicare and Medicaid Services (CMS) and the Indian Health Service (IHS), but this is <u>not</u> an official document issued by the federal government.

3	AI is a member of a Tribe that does not provide health care directly, but has a CHS-only program for tribal members.	No CHS referral is needed for in-network or out-of-network EHB services. A CHS authorization would be needed if the service is a non-EHB, or if an out-of-network provider charges the balance billing amount to patients (ie, the amount that the insurance company does not pay and is not covered by co-pays or deductibles).	CHS referral is needed for both in-network and out-of-network EHB services. The CHS referral may be a paper form, an e-mail or a card issued by the I/T/U authorizing CHS on an open-ended basis. A CHS authorization would be needed if the service is a non-EHB, or if an out-of-network provider charges the balance billing amount to patients (ie, the amount that the insurance company does not pay and is not covered by co-pays or deductibles).
4	AI/AN goes to an in-network I/T/U provider for a **specialty medical visit, a procedure, or a surgery.**	I/T/U primary care provider can make the plan referral (if one is required by the plan) and no CHS referral is needed. Pt pays no cost sharing. Plan pays provider the contracted amount with no deduction for patient cost sharing.	I/T/U primary care provider can make the plan referral (if one is required by the plan) and no CHS referral is needed. Pt pays no cost sharing. Plan pays provider the contracted amount with no deduction for patient cost sharing.
5	AI/AN goes to an out-of-network I/T/U provider for a **specialty medical visit, a procedure, or a surgery.**	The patient does not need a CHS referral for an I/T/U provider. Patient has no cost sharing for the I/T/U, as long as it is a covered service. • If the plan requires a plan referral for a specialty medical provider (either in-network or out-of network) and the patient does not have the plan referral from an in-network primary care provider, then the plan may set the patient's cost sharing at 100 percent of the cost of the service. The patient would not have to pay the cost sharing. Plan pays I/T/U provider the amount it would pay to other out-	The patient does not need a CHS referral for an I/T/U provider. Patient has no cost sharing for the I/T/U, as long as it is a covered service. • If the plan requires a referral for a specialty medical provider (either in-network or out-of network) and the patient does not have the plan referral from an in-network primary care provider, then the plan may set the patient's cost sharing at 100 percent of the cost of the service. The patient would not have to pay the cost sharing. Plan pays I/T/U provider the amount it would pay to other out-of

		of network providers for the same service plus the amount for patient cost sharing that has been exempted for patient payment. • If the plan rules state that there is no payment for out-of-network providers without a plan referral, then the I/T/U can still bill the plan for the service provided under Sec. 206 of IHCIA and the plan must pay the amount without deducting cost-sharing that would otherwise be charged to the patient.	network providers for the same service plus the amount for patient cost sharing that has been exempted for patient payment. • If the plan rules state that there is no payment for out-of-network providers without a plan referral, then the I/T/U can still bill the plan for the service provided under Sec. 206 of IHCIA and the plan must pay the amount without deducting cost-sharing that would otherwise be charged to the patient.
6	AI/AN goes to <u>non-I/T/U in-network provider</u> for primary care or specialty care.	No CHS referral is needed for EHB services. Patient pays no cost sharing. Plan may require a referral from a primary care provider to a specialist, but the specialty medical provider should enforce this (ie, no plan referral, no service). If the service is non-EHB, then a CHS authorization would be required in order for the patient to avoid being responsible for any costs.	Patient needs a CHS referral to avoid any co-pays or deductibles for EHB services. The CHS referral may be a paper form, an e-mail or a card issued by the I/T/U authorizing CHS on a open-ended basis. The CHS referral may be issued before or after the appointment. If the patient has the referral at the time of the appointment, the patient should not have to pay any cost-sharing. If the referral is issued after the service is provided, the plan should refund to the patient any cost sharing that was collected at the time of the appointment. CHS may issue these types of referrals to people who are eligible for IHS and live outside the CHSDA; however, such referrals are not authorizations for payment.

7	AI/AN goes to a non-I/T/U out-of-network provider for primary care or specialty care.	• If the plan requires a plan referral to go out-of-network and the patient has the plan referral, there should be no cost sharing for the patient for EHB services. If the patient does not have a plan referral, then a CHS authorization may needed to pick up the entire amount of the out-of-network visit (minus any cost-sharing). • If the plan does **not** require a plan referral to go out-of-network, then the patient should have no cost sharing for EHB services. However, if the out-of-network provider charges balance billing, then a CHS authorization is needed for the balanced billing amount. • If the plan does not pay for any out-of-network providers, then a CHS authorization is needed for the full amount.	• The best protection for the patient is for CHS is issue an authorization for these services, which also serves as a referral. • If the plan requires a plan referral to go out-of-network and the patient has the plan referral, then a CHS referral is also needed to avoid cost sharing for EHB services. If the patient does not have a plan referral, then a CHS authorization is needed to pick up the entire amount of the out-of-network visit. • If the plan does **not** require a plan referral to go out-of-network, then a CHS referral is needed to avoid cost sharing for EHB services. If the out-of-network provider charges balance billing (the amount not paid by the plan or the patient co-pays or deductibles), then a CHS authorization is needed for the balanced billing amount. • If the plan does not pay for any out-of-network providers, then a CHS authorization is needed for the full amount.