NPAIHB POLICY UPDATE
IHS Medicare-like Rates

PREPARED BY: NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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The IHS Contract Health Service Program and Medicare-like Rates

The Medicare Modernization Act (MMA) includes a provision (Section 506) that would require hospitals that participate in the Medicare program to accept Medicare-like rates as payment in full when providing services to individuals under the Contract Health Service (CHS) program of the Indian Health Service (IHS). The new law will provide IHS and Tribally-operated CHS programs with similar benefits to those enjoyed by of other Federal purchasers of health care. Indian health programs will now benefit from Medicare's bargaining power when purchasing specialty care for their non-Medicare patients.

The MMA mandated that this provision "shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 1 year after the date of enactment of this Act) to Medicare participation agreements in effect (or entered into) on or after such date". Unfortunately, it has taken the Administration and the Department of Health and Human Services (HHS) over two years to implement this important cost saving provision—thereby costing the federal government, IHS and Tribally-operated health programs, and American taxpayers millions of dollars. It is estimated that the cost savings from the implementation of this regulation is at least $75 million for the fiscal years 2004 to 2006.

The Indian Contract Health Service Program

The Indian healthcare system, which is comprised of the Indian Health Service, Tribes or Tribal Organizations, and Urban Indian Organizations (I/T/U), provides direct primary and preventive health care services to eligible patients. The Indian health system must routinely purchase more specialized services for their beneficiaries from public and private providers through the CHS program. Although IHS and Tribes work to negotiate reasonable rates from local providers, the small market share of individual CHS programs makes it difficult for the Indian health system to secure low rates for the CHS services it purchases. In order to stay within limited CHS program budgets, IHS and Tribes have been forced to apply stringent medical priorities for use of CHS

IHS Contract Health Service Program
Summary of Unfunded Need in FY 2005

Category	Number of Services	Estimated CHS Resource Need
Deferred Services Within Medical Priorities	158,884	$152,687,524
Eligible But Care Not Within Medical Priorities	33,106	$31,814,866
Eligible But Alternate Resource Available	65,398	$62,847,478
Emergency Notification Not Within 72 Hours	9,434	$9,066,074
Non-Emergency No Prior Approval	19,259	$18,507,899
Patient Resides Outside CHSDA	8,612	$8,276,132
Unfund CHEF Cases (actual costs)	802	$17,971,608
TOTAL:	295,495	$301,171,581

funds, as the number of patients in need of services routinely exceeds the funding available. While other Federal purchasers of health care have legislation requiring private hospitals to offer services at favorable Medicare rates, IHS did not have this benefit until recently.

The Indian health system's annual CHS budget is $517 million to cover the specialty care needs of over 550 Tribes. It is estimated that the unmet need for CHS resources is at least $301 million based on FY 2005 data. This figure could be significantly higher if CHS data from Tribal programs were available. The IHS maintains a deferred and denied services report that is updated each year. The report is inclusive of CHS data from IHS direct operated health programs and includes limited data from Tribally-operated health programs. Unfortunately, the deferred/denied services report **understate** the true need of CHS resources due to the data limitations and the fact that many tribes no longer report deferred or denied services because of the expense involved in reporting. More disturbing is that many IHS users do not even visit health facilities because they know they will be denied services due to funding shortfalls. Thus, the estimate of $301 million is quite conservative and when added to the current CHS budget line item should be at least $800 million.

In order to budget CHS resources, so that as many services as possible can be provided, the agency applies stringent eligibility rules and uses a medical priority system. The regulations at 42 Code of Federal Regulations (CFR) Part 136 require that CHS services must be authorized or no payment will be made. Non-emergency services must be pre-authorized and emergency services are only authorized if notification is provided within 72 hours of the patient's admission for emergency treatment. The agency also has adopted the financial position that it is the Payer of Last Resort. This requires patients to exhaust all health care resources available to them from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. The IHS also negotiates contracts with providers to ensure competitive pricing for the services provided; however, there may be only one or a limited number of providers or vendors available to the local community. The CHS authorizing official from each I/T either approves or denies payment for an episode of care. If payment is approved, a purchase order is issued and provided to the private sector hospital.

The CHS regulations permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of care needed. These priorities are categorized into four Priority Levels and described as follows:

> Priority One - Emergent/Acutely Urgent Care Services: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available. ***Priority One*** represents those diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.
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> Priority Two - Preventive Care Service: Primary health care that is aimed at the prevention of disease or disability. This includes services proven effective in avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention).
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> Priority Three - Chronic Primary and Secondary Care Services: Inpatient and outpatient care services that involve the treatment of prevalent illnesses or conditions that have a significant

impact on morbidity and mortality. This involves treatment-for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It includes services that may not be available at many IHS facilities and/or may require specialty consultation.

Priority Four - Chronic Tertiary Care Services: Inpatient and outpatient care services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, elective, and often require tertiary care facilities.

The implementation of the Section 506 regulations would save millions of for IHS and Tribally-operated CHS programs and expand services to American Indian and Alaska Native health beneficiaries. If the Section 506 regulations were in effect, the IHS system could apply at least $75 million in savings to a backlog of patient services that cannot be accommodated in the current CHS program. The passage of these regulations could virtually save lives of Indian people, however the Administration and HHS have not seen the priority in working to approve and implement this very important provision even though Congress directed the implementation of these regulations to occur not more than one year after enactment of the MMA.

Medicare-like Rate Cost Analysis

In January 1999, the HHS-OIG report found that the IHS system as a federal purchaser of health services from the private sector should be receiving rates commensurate with other federal agencies (i.e. Medicare, Medicaid, VA programs) who engage in similar purchases.[1]

In the Inspector General's review, it was estimated that the CHS program could save at least $8.2 million in costs if inpatient providers accepted reimbursement not to exceed the Medicare rate. This projection was based on limited CHS data from 1995 and certainly today, this estimate would be significantly higher. The HHS-OIG report was limited to those Tribes served by 118 hospitals and did not include CHS expenditures for Tribally-operated programs under the Indian Self-Determination and Education Assistance Act. It was also limited to those Medicare providers paid over $100,000 or more by IHS. While the data is limited it does provide a basis for estimating the cost savings that Section 506 would provide. Certainly, these estimates would be significantly higher if Tribally-operated CHS program data were included.

Hospitals Charging more than Medicare Rates
for Hospitals where IHS paid more than $100,000

Percentage Higher Than Medicare	No. of Hospitals	1999 Amount IHS Paid Higher than Medicare	2003 Inflation Adjusted Amount [1]
0% to 10%	27	$402,784	$546,663
11% to 40%	25	$4,650,958	$6,312,328
41% to 67%	15	$3,096,471	$4,202,562
TOTAL:	67	$8,150,213	$11,061,552

[1] Souce: Bureau of Labor Statistics Series: CPI Index ID No. CUSR0000SS5702, "Inpatient Hospital Services" adjusted seasonally, 1999-2003.

Adjusting the HHS-OIG estimates for inflation indicate that the $8.2 million in cost savings would be approximately $11 million in FY 2003 when the Medicare-like rate provision was passed. Further applying the inflationary growth of 13.1% for hospital inpatient services from FY 2003 to FY 2006 to the

[1] Review of Indian Health Service's CHS Program", HHS/OIG Report CIN: A-15-97-50001, January 21, 1999.

HHS-OIG estimated Medicare-like rate cost savings makes this amount over $12.5 million.[2] This projection is extremely low since there are many more services that could be included in the sample because of IHS' expanded Part B billing authority (MMA Section 603) and the fact that the initial estimate did not include Tribally-operated CHS data. This information does however allow us to further estimate the potential cost savings of Medicare-like rates.

In FY 2006, the IHS Congressional Justification document indicates that approximately 52% of the CHS program is administered by Tribes. If this is used as a basis to apply to the projected Medicare-like rate cost savings for HHS-OIG report, then an estimate for the Tribally-administered portion of the CHS program can be derived. The HHS-OIG Medicare-like rate cost savings adjusted for inflation is $12.5 million. Applying the Tribally-administered portion of the CHS program to this assumption calculates an estimated cost savings of $25 million for the CHS program. Using this as an estimate to calculate the cost savings since the time that Section 506 should have been effectively implemented indicates that Medicare-like rates had the potential to save at least $75 million in the CHS program. Again, this amount is very conservative and would be more when expanded Part B billing authority and the additional services are factored. It is also anticipated that the final Section 506 Medicare-like rate regulations will apply to all CHS referred inpatient and outpatient services provided to IHS eligible beneficiaries. Thus, the number of services would be greatly expanded and not just limited to those inpatient services that were reviewed and reported in the HHS-OIG report. Thus, the $75 million is a very conservative estimate that will end up being significantly more.

IHS Contract Health Service Program
Distribution of Administration
FY 2006 Budget in Thousands

CHS Operated By:	FY 2007 CHS Budget	Percent
Federal Administration	$247,601	48%
Tribal Administration	$269,696	52%
TOTAL, CHS	$517,297	100%

Development of Medicare-like Rate Regulations

In May 2004, the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare & Medicaid Services (CMS) organized a subcommittee to assist CMS and the IHS in the development of regulations to implement Section 506. The Subcommittee first met in June 2004 to develop recommendations to be included in the regulations. This information was discussed over a series of conference calls between July and August 2004. A draft copy of the Section 506 regulations was finalized and provided to CMS and the IHS at the September 22-23, 2004 TTAG meeting. It was hoped that the regulations could be finalized and published for public comment prior to the effective date of the provision, December 4, 2004; or a date specified by the Secretary, but no later than one year after enactment of the MMA—as stipulated in MMA legislation. Since September 2004, HHS has indicated that the Section 506 regulations are going through internal review procedures and will require Office of Management and Budget (OMB) clearance. Almost two years after the regulations were developed it has finally been reported by HHS that the Secretary has approved the regulations and they have been sent over to OMB.

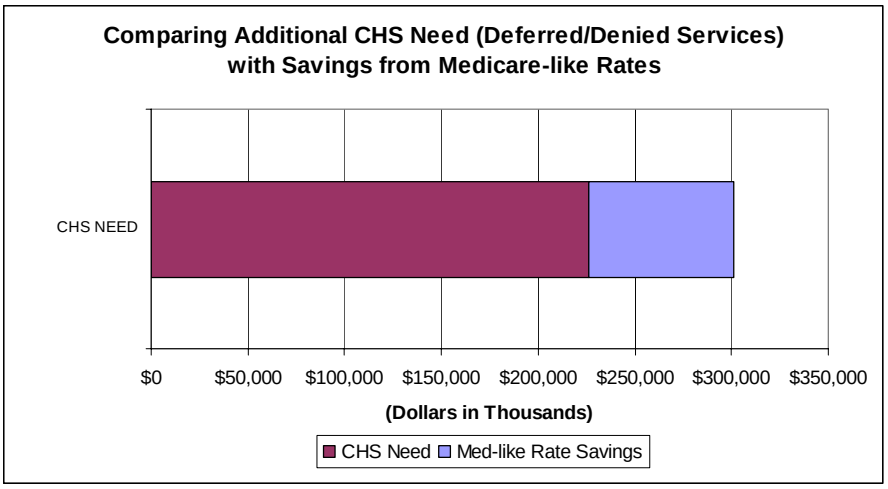
It has been almost two years since draft guidelines for implementing Section 506 were developed and is the most delinquent task that CMS/IHS has on the TTAG agenda. This issue has serious budgetary

[2] Source: Bureau of Labor Statistics, CPI Index ID No. CUSR0000SS5702, "Inpatient Hospital Services" seasonally adjusted index, January 2003 – February 2006."

impact ($75 million in last three years) on the CHS program and three years of potential costs savings have been lost by IHS programs. While it is good news that the regulations have finally been sent to OMB, it is questionable whether Tribes will be able to benefit from the regulations this year. Some Tribes may have entered into CHS rate agreements for this year and are bound by those agreements; and new ones currently could be under negotiation that would lock in rates for 2007. Even after the regulations become final, the newly negotiated contract rates may prevail when purchasing specialty care. Thus, it is imperative that OMB approve the CHS implementation regulations so that IHS and Tribal health programs can take advantage of this new benefit.

Conclusion

The most important point of this analysis is that the new Medicare-like rate provision does mean significant resources for IHS and Tribally-operated CHS programs. The cost savings from the new regulation will easily exceed the annual appropriations increase that the CHS program receives. Since 1997, the CHS program has averaged less than $16 million each year. The Medicaid-like rate regulations stand to save the IHS system at least $25 million or more per year. This expanded purchasing power can be used to provide more health services and off-set over 295,000 denied and deferred services that affect the health and well-being of American Indian and Alaska Native people.



The lost savings of $75 million over the last three years could have easily addressed 25% of last years CHS backlog of denied and deferred services and made health care services available to Indian people that had to go without service. The Medicare-like rate cost savings can be used to reduce the backlog of over $300 million in deferred and denied services and the Administration and HHS should move swiftly to approve the final regulations in implement Section 506 of the MMA.

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