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MEMORANDUM

October 28, 2013

TO: Tribal Health Clients

FROM: Hobbs, Straus, Dean & Walker LLP

Re: ***Update on Medicare-Like Rate Cap Expansion***

The "Medicare-Like Rate" cap allows Contract Health Service (CHS) programs to pay hospital providers no more than what Medicare would pay for the same service. Currently, the cap applies only to hospital providers, which represent only a portion of the services provided through the CHS system. On April 11, 2013, the GAO issued a report that recommended that Congress enact legislation that would expand the Medicare-Like Rate cap to all Medicare participating providers, and the Department of Health and Human Services agreed with that recommendation.

We have been working on behalf of a number of our tribal clients to enact legislation that would expand the Medicare-Like Rate to non-hospital Medicare participating providers and suppliers. We have prepared a draft bill, along with a white paper explaining the need for the legislation (Attached), and are working with a number of tribes and tribal organizations including USET and the National Indian Health Board to get the bill introduced in Congress. We have also learned that IHS is exploring the possibility of expanding the Medicare-Like Rate Cap to non-hospital services through regulations, and we are following that possibility closely as well.

Following is a brief update on this important initiative.

Need for the Expansion

The GAO report notes that IHS and tribal CHS programs often pay full billed, non-negotiated rates that can amount to double or more the rate that Medicare would pay. Expanding the Medicare-Like Rate to all services purchased through the CHS program could save hundreds of millions of dollars and thereby greatly increase access to, and services provided under, the CHS program. It would allow CHS programs to apply a Medicare-Like Rate cap to services provided by all manner of providers, including physicians, anesthesiology assistants, nurse practitioners, ambulance services, air and ground transport, specialists, renal dialysis, x-ray technicians, independent diagnostic test facilities, independent clinical laboratories, clinics, physical therapists, and the like. The savings it generates would allow CHS programs to begin making more referrals sooner.

The CHS program may be the only remaining federal program that continues to pay full billed charges for medical care. Both the Department of Defense and the Veterans Administration, for example, pay capped rates for all the outside health care services they need, not just hospital services. In a time of declining federal budgets and sequestration, the need to save scarce health care resources is at a premium. Expanding the Medicare-Like Rate Cap to all services is budget neutral, yet would result in vast new resources in the form of savings being made available to the chronically underfunded CHS programs.

Legislative Approach

We are working to identify a sponsor for the bill and are coordinating our efforts with a number of tribal representatives from USET, NIHB and others. There are several House members who have expressed significant interest in the bill and we hope to be able to identify an appropriate sponsor in the near future. Once we have identified a sponsor, we will be able to vet the language of the draft bill through legislative counsel and expand our efforts to pick up co-sponsors and move the legislation forward.

In our view this bill is entirely non-partisan and budget neutral. We believe it would benefit from having a Republican sponsor in the House and are reaching out to several members who have expressed interest. We are also looking for sponsors on the Senate side as well. Please let us know if you would like to assist in that effort.

One request we have been hearing on the Hill is for tribal letters of support on tribal letterhead. NIHB has developed a model draft letter of support which we assisted with. The letter is attached.

Potential Regulatory Approach

We have learned that the IHS is considering a regulatory approach to expanding Medicare-Like Rates to non-hospital services. We have discussed this possibility with IHS staff, and have asked to consult with the IHS on this potential approach but have not yet received any commitment from IHS to a meeting. There are positives and negatives associated with a regulatory approach and we hope that IHS will consult with tribes before moving forward. We will continue to monitor and seek to engage with IHS on this potential approach.

Conclusion

If you have questions about this effort, please contact Elliott Milhollin at (202)822-8282 or emilhollin@hobbsstraus.com; Geoff Strommer at (503)242-1745 or gstrommer@hobbsstraus.com; or Karen Funk at (202)822-8282 or kfunk@hobbsstraus.com.

Purpose: To amend title XVIII of the Social Security Act to provide for a limitation on the charges for contract health services provided to Indians by Medicare providers.

At the end of title ____, add the following:

Sec. _____. **LIMITATION ON CHARGES FOR CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PROVIDERS.**

(a) ALL PROVIDERS OF SERVICES. –

(1) IN GENERAL.—Section 1866(a)(1)(U) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(U)) is amended by striking "in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title," in the matter preceding clause (i).

(2) Regulations. The regulations published by the Secretary on June 4, 2007 at 72 Fed. Reg. 30706, *et seq.* with regard to hospitals which furnish inpatient hospital services regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services) shall remain in effect.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to Medicare participation agreements in effect (or entered into) on or after the date that is 90 days after the date of enactment of this Act.

(b) ALL SUPPLIERS.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(p) LIMITATION ON CHARGES FOR CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY SUPPLIERS.—No payment may be made under this title for an item or service furnished by a supplier (as defined in section 1861(d)) unless the supplier agrees (pursuant to a process established by the Secretary) to be a participating provider of medical and other health services both—

"(1) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

"(2) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding payment methodology and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after the date that is 90 days after the date of enactment of this Act.

PROPOSAL – EXTEND THE MEDICARE-LIKE RATE CAP ON CHS REFERRALS TO ALL MEDICARE PARTICIPATING PROVIDERS AND SUPPLIERS

The Indian Health System Overpays for Non-Hospital Services

The Indian Health Service (IHS), Indian tribes and tribal organizations currently cap the rates they will pay for hospital services to what the Medicare program would pay for the same service (the "Medicare-Like Rate"). Currently, this Medicare-Like Rate cap applies only to hospital services, which represent only a fraction of the services provided through the CHS system.

Contract Health Service (CHS) programs continue to routinely pay full billed charges for non-hospital services, including physician services. The CHS program may be the only plan in the Federal Government that does so. Neither the Department of Defense nor the VA pay full billed charges for health care from outside providers. Nor do insurance companies, including those with whom the federal government has negotiated favorable rates through the Federal Employee Health Benefits program. Full billed charges can widely vary from provider to provider, and often vastly exceed what Medicare would pay. As widely reported, the Center for Medicare and Medicaid Services recently released hospital pricing data that demonstrates that the full billed charges for hospital services are often many multiples of the rates Medicare would pay for the same services.[1]

On April 11, 2013, the Government Accountability Office (GAO) issued a groundbreaking report that concluded that the IHS CHS program routinely pays full billed charges for non-hospital services, resulting in needless waste of scarce CHS program dollars.[2] The GAO Report concludes that expanding the Medicare-Like Rate Cap to cover all services purchased under the CHS program would result in hundreds of millions of dollars in savings to Contract Health Service programs across the country. The GAO Report notes that the Department of Veterans' Affairs has already implemented a Medicare-Like Rate for the services it contracts for outside the VA system, and recommends that Congress enact legislation that would allow the IHS to do the same. Implementing a Medicare-Like Rate on all non-hospital services is budget neutral, and would greatly increase the level of care that Indian health programs are able to provide to American Indians and Alaska Natives at no additional cost to the government.

The Medicare-Like Rate Cap Currently Applies Only to Hospital Services

In 2003, Congress amended the Medicare law to authorize the Secretary of Health and Human Services to establish a rate cap on the amount hospitals may charge IHS and tribal health programs for care purchased from hospitals under the CHS program. The amendment was modeled on existing laws that granted the VA and DOD similar authority. In 2007, the Secretary

[1] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html.

[2] Indian Health Service: Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services. GAO-13-272.

issued regulations which established a Medicare-Like Rate cap for CHS services, but it applied only to hospital services.

The GAO and HHS Recommend Extending the Medicare-Like Rate Cap to All Services

The Government Accountability Office (GAO) recently examined the CHS program, and concluded that the Medicare-Like Rate Cap should be expanded to cover all services purchased under the CHS program. In a report issued April 11, 2013, the GAO concluded that "Congress should consider imposing a cap on payments for physician and other nonhospital services made through IHS's CHS program that is consistent with the rate paid by other federal agencies." The Department of Health and Human Services (HHS) has reviewed the report and concurs with GAO's conclusions and recommendations.

The GAO Report found that the vast majority of IHS's federal CHS program payments were made at non-negotiated rates, and that these rates cost on average nearly 70 percent more than negotiated rates. GAO found that federal CHS programs paid non-contracted physicians two and half times more than what it estimates Medicare would have paid for the same services.

The GAO Report looked only at data it compiled from CHS programs run by the IHS. It did not look at the entire CHS program, which includes both the IHS and Tribal programs operating under the Indian Self-Determination and Education Assistance Act.

The GAO concluded that IHS CHS programs paid two times more than they would have paid with a Medicare-Like Rate in place, and that the IHS CHS program alone would have saved an estimated $31.7 million annually if Medicare-Like Rates applied to non-hospital services. These savings would result in IHS being able to provide approximately 253,000 additional physician services annually.

Although the GAO estimates are likely quite conservative, the GAO estimates that tribal CHS programs could have saved an additional $68.2 million for services provided in 2010 alone. GAO estimates that tribal and federal CHS programs combined could have saved $126.4 million in 2010 alone if Medicare-Like Rates had been in place for non-hospital services.

Using even these conservative estimates, the expansion of the Medicare-Like Rate Cap from 2010 to the present would have resulted in hundreds of millions in new federal health care resources being made available to American Indians and Alaska Natives.

The Proposed Legislation Directs the Secretary to Expand the Medicare-Like Rates Cap

The proposed legislation would amend Section 1866 of the Social Security Act to expand application of the Medicare-Like Rate Cap. It would direct the Secretary to issue new regulations to establish a payment rate cap applicable to medical and other health services in addition to the current law's cap on services provided by hospitals. It would make the Medicare-Like Rate cap apply to all Medicare-participating providers and suppliers. This would include physicians, anesthesiology assistants, nurse practitioners, ambulance services, air and ground transport, specialists, renal dialysis, x-ray technicians, independent diagnostic test facilities,

independent clinical laboratories, clinics, physical therapists, and the like. At the same time, it would preserve existing regulations that impose a Medicare-like Rate cap for services provided by hospitals.

The Proposed Legislation is Designed to Ensure Continued Access to Care

The GAO report concluded that any expansion of Medicare-Like Rates to non-hospital services would need to ensure that Indians have continued access to health care providers. The proposed legislation helps to ensure continued access to providers by making it a requirement for all Medicare-participating providers and suppliers, including physicians, to accept the rates of payment set by the Secretary as payment in full as a condition of receiving Medicare payments.

Under the proposed legislation, if a provider or supplier refused to accept that rate of payment, they would no longer be eligible to receive any Medicare payments. However, any provider or supplier would be free to reject that rate and no longer participate in Medicare.

The proposed legislation calls for the Secretary to develop new regulations to set the actual rate of payment, which is expected to be the Medicare-Like Rate. Any new regulations would be subject to tribal consultation and notice and comment rulemaking. One option to be considered would be to develop a process modeled on the VA's regulations, which allows for a higher rate than the Medicare-Like Rate to be used when necessary to ensure continued access to providers.

The proposed legislation is likely to have a minimal impact on existing providers and suppliers. Indians make up less than one to two percent of the total demand for care nationally. As the GAO report points out, most providers and suppliers already participate in Medicare, and are used to paying Medicare rates for services.

The Proposed Legislation is Budget Neutral and Consistent with Federal Policy

The proposed legislation could result in hundreds of millions of dollars in savings being made available to the IHS and Tribal and urban Indian health care facilities at no cost to the government. The legislation is budget neutral. The cost savings it would produce will be critical in coming years, as IHS is not subject to any cap on Budget Sequestration.

These cost savings would allow tribal health care programs to change their present level of care to a more favorable level of care, and treat lower priority cases early, before they develop into more serious problems. This, in turn, would result in significant cost savings not accounted for in the GAO's estimates, and dramatically improve health outcomes for one of the most at-risk populations in the United States.

Finally, expanding the Medicare-Like Rate Cap would bring IHS billing and payment policy in line with other federal agencies, such as VA and DOD, which already impose a Medicare-equivalent rate for non-hospital services.

[DATE]

The Honorable **[INSERT REPRESENTATIVE OR SENATOR]**
INSERT ADDRESS
Washington, DC

Dear [Representative/ Senator X]:

Dear [X],

On behalf of [**INSERT NAME OF TRIBE/TRIBAL ORGANIZATION HERE**] we offer this letter of support to extend the Medicare-Like Rate (MLR) cap on Contract Health Services (CHS) to all non-hospital Medicare participating providers and suppliers. Expanding the Medicare-Like Rate cap is a budget-neutral cost-savings mechanism that will allow IHS and Tribal facilities to stretch limited CHS dollars further and create parity with other federally-funded health systems. We echo the recommendation of the Government Accountability Office (GAO) report released on April 11, 2013 and request that Congress enact legislation that would allow HHS to extend the MLR cap to all Medicare participating providers and suppliers.

CHS programs are the only federal health care programs that continue to pay full billed charges for non-hospital services. On average, full billed charges are nearly 70 percent more than negotiated rates. The GAO report estimates that by expanding the MLR to non-hospital services, IHS and tribal CHS programs would be able to save hundreds of millions of dollars and dramatically increase the care they are able to provide. As discretionary spending grows scarce, this is a common-sense solution that would use federal dollars more efficiently. The Veteran's Administration and the Department of Defense have already capped their rates for non-hospital providers and CHS programs should be authorized to do so as well.

The GAO report found that this pricing mechanism would have little impact on access to providers, which is already a chronic need in Indian Country. The proposed legislation would require that any provider accepting Medicare to also accept MLR for payments billed to CHS programs. As the GAO report points out, most providers and suppliers already participate in Medicare, and are used to paying Medicare rates for services.

We appreciate the opportunity to offer this letter of support capping all CHS payments at Medicare-Like Rates. Should you have questions or need additional information, please do not hesitate to contact **[INSERT CONTACT NAME]** at [**INSERT CONTACT INFORMATION].**

Sincerely,

[**INSERT NAME AND TITLE**]