

# Tribal Technical Advisory Group

to the Centers for Medicare and Medicaid Services

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July 15, 2004

Mark McClellan, M.D., PH.D  
Administrator  
Centers for Medicare and Medicaid Services  
200 Independence Avenue, S.W.  
Hubert H. Humphrey Building  
Washington, DC 20201

Re: Implementation of Medicare Like Rates

Dear Dr. McClellan:

Thank you again for taking time from your busy schedule to meet with the Tribal Technical Advisory Group on May 22, 2004. We have been busy at work since that meeting on priorities determined at that meeting. One critical task concerns Section 506 of the Medicare Modernization Act (MMA) that will require enrolled Medicare hospitals to accept no more than Medicare-like rates as payment in full for services provided to Indian patients referred by Indian Health Service (IHS) and Tribally operated Contract Health Service (CHS) programs. This new law gives Indian health programs similar protection to that enjoyed since the mid-1980s by the Veterans Administration and the Department of Defense. Indian health programs may now benefit from Medicare's bargaining power when purchasing care for their CHS beneficiaries.

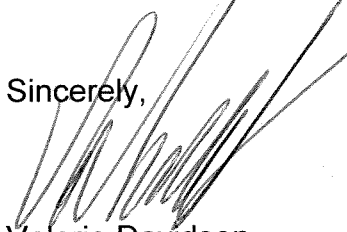
The amendments specified in Section 506 are to take effect on a date specified by the Secretary but in no case later than one year after the date of enactment of the MMA, December 2004. Because this deadline is rapidly approaching, the CMS Tribal Technical Advisory Committee (TTAG) hereby requests that you elevate Section 506 as a priority by assigning appropriate CMS staff to meet with the TTAG Medicare-Like Rate subcommittee. In our efforts to engage CMS personnel that were assigned to the Medicare Like Rate subcommittee (Sue Burris, Larry Stevens, Ed Gill) we were informed that these individuals specialize in cost reports for Medicare and are not the appropriate people to engage in developing regulations for the new law.

The TTAG Medicare Like Rate subcommittee has prepared the attached guidelines for your consideration as CMS begins to develop regulations for implementing Section 506. We would further request a meeting with you or assigned CMS staff to discuss the issues that are outlined in proposed guideline document. Because of the timeline associated with the implementation of Sec. 506, we propose meeting sometime this month, July 2004.

It is imperative that the TTAG has an opportunity to discuss with CMS staff the administrative and operational issues associated with hospital reimbursements to be made under Section 506 by IHS and Tribal CHS programs. There are many areas of concern that will need to be resolved prior to implementation of Section 506. Some of those concerns include the CHS payment process, Indian Health Service, Tribal and Urban Indian Health Programs (ITUs) and retrospective analysis, appeal provisions, referral and continuity of care considerations, types of charges to be covered, and rate methodologies to name a few. I am also sure that there will be other issues that arise as the subcommittee meets with CMS staff to work on this provision.

We look forward to meeting with CMS staff and thank you for your attention to this very important matter. If you have any questions concerning the information in this letter or the attached guidelines, please feel free to contact Ed Fox, Chair, TTAG Medicare Like Rate subcommittee, at (503) 228-4185 or by email at [efox@npaihb.org](mailto:efox@npaihb.org). Mr. Fox or his staff will also follow up with your office to set-up a meeting shortly.

Sincerely,



Valerie Davidson  
Chair, CMS Tribal Technical Advisory Group  
Executive Vice-President,  
Yukon-Kuskokwim Health Corporation

Enclosure: Proposed Guidelines for Medicare Like Rates

cc: Dr. Charles Grim, IHS Director  
Dorothy Dupree, CMS  
TTAG Representatives

**PROPOSED GUIDELINES FOR IMPLEMENTATION OF  
SEC. 506 OF THE MEDICARE MODERNIZATION ACT  
REGARDING ESTABLISHMENT OF "MEDICARE-LIKE RATES"  
FOR THE CONTRACT HEALTH SERVICE PROGRAMS FUNDED  
BY THE INDIAN HEALTH SERVICE**

Prepared: July 8, 2004

**A. Background Information**

1. The Contract Health Services Program

The Indian healthcare system, which 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 I/T/Us must routinely purchase more specialized services for their beneficiaries from public and private providers through the Contract Health Services (CHS) program. Although the I/T/Us work to negotiate reasonable rates from local providers, the small market share of individual CHS programs makes it difficult for an I/T/U to secure low rates for the CHS services it purchases. In order to stay within limited CHS program budgets, I/T/Us have been forced to apply stringent medical priorities for use of CHS funds, as the number of patients in need of services routinely exceeds the funding available.

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. As a part of the authorization process, the IHS both refers patients and arranges for patient transfers to particular providers. Generally, the I/T/U has had to pay full billed charges, which substantially exceed the Medicare allowable rates, for CHS services.

I/T/Us will now benefit from Medicare's determination of appropriate rates when buying care for their non-Medicare patients due to the provisions established in section 506 of the Medicare Modernization Act (MMA). Section 506 requires Medicare-participating hospitals to accept no more than Medicare-like rates (as set by the Secretary in regulations) from the Indian health programs as payment in full. The statute does not expressly state that Medicare rates must be used as the maximum rates. Thus, it is necessary for the Secretary to issue regulations or guidance that describes the payment rates. This change will be effective for hospitals with Medicare participation agreements in effect or entered into on or after a date specified by the Secretary, no later than December 8, 2004.

2. The contract health service payment process

A patient may either be referred by staff of an I/T/U to a private sector hospital or in an emergency a patient might obtain care at a private sector hospital without being referred from an I/T/U facility. The CHS authorizing official from each I/T/U either approves or denies payment for an episode of care. The determination to approve payment is based on a number of criteria. Generally, at each I/T/U a menu of services is developed and organized by priority so that less critical services can be deleted from the menu if resources are determined to be inadequate. If payment is approved, a purchase order is issued and provided to the private sector hospital. The staff of a private sector hospital should be required to submit, as instructed, the purchase order and other required information to the one of the following organizations: IHS/CHS/Fiscal Intermediary (FI), Area finance office, or to other organizations that the Tribe uses to pay their medical bills.

3. The I/T/Us Do Not Conduct Retrospective Analysis

The IHS programs must be operated within the dollar amount of the annual appropriations from Congress and are subject to the Anti-Deficiency Act. Because of the annual cap on CHS appropriation, this program cannot accommodate retrospective analyses where payment obligations may not be fully quantified until 1 or more years after the CHS referral occurs. It may take many years to obtain an audited, settled cost report for a non-IHS hospital to which Indian beneficiaries are referred for care under the IHS's CHS program. Tribal health programs have somewhat greater flexibility than the IHS and Urban programs, but they generally do not have fiscal management systems capable of tracking multi-year retrospective settlements.

The term, "Medicare like rates", describes the rate at which private sector hospitals will be reimbursed by I/T/Us. Because the payment methodology used by I/T/Us is slightly different from the Medicare methodology, the reimbursement rates will not be identical.

4. Appeal Provisions

The CHS program has provisions for patients and providers to appeal payment denial determinations. The IHS has established procedures, and tribally operated programs may either use the IHS system or establish their own procedures. When a denial is issued, instructions will be provided concerning the appropriate appeal procedure.

5. The I/T/Us are Responsible for Providing Care in addition to Paying for Care in Private Sector Hospitals

Each I/T/U uses established criteria in deciding to which hospital a patient will be

referred. Once a patient is in a private sector hospital, the staff of the I/T/U monitors the patient's care and, if necessary, takes appropriate action. After the patient is discharged from the private sector hospital, the I/T/U that referred the patient is responsible for providing the required follow up care. In order to carry out these responsibilities, the staff of the I/T/U may need necessary medical documentation to be provided on an ongoing basis by the private sector hospital

## **B. Implementation of Sec. 506 of the MMA**

When the enrolled provider or payee is a hospital Section 506 applies to the following:

- Acute Care charges
- Rehabilitation Services charges
- Skilled Nursing Services charges
- Mental Health services charges
- Swing Beds charges
- Emergency Room charges
- Provider-based Outpatient clinic charges
- Provider-based Outpatient surgery charges
- Ancillary services charges
- Provider-based Pharmacy charges
- Provider-based Hospice charges
- Provider-based Home health charges

## **C. Rate Methodology**

With some modifications, we suggest that the payment rate for the IHS-funded CHS program be set at a rate no greater than the allowed amount according to the most recent Medicare Methodology. To avoid hospitals charging I/T/Us at rates higher than the Medicare Methodology may allow, it is the responsibility of the I/T/Us to calculate the maximum allowable payment rates. The Secretary should publish regulations or guidance memoranda which describe and explain the payment methodology applicable to such services. The Secretary does not publish the dollar amount that will be paid to each hospital for every inpatient admission or outpatient service. See the table below for Federal Register and CFR citations that describe the Medicare Methodology that is used in various types of hospital settings:

Page 4 - Guidelines for Implementing Section 506 of MMA

Type of service	Federal Register Citation	CMS Website(s) <a href="http://www.cms.hhs.gov/providers/hospital">www.cms.hhs.gov/providers/hospital</a>
Acute Care (DRG)	Vol. 68, N0.148, Friday, August 1, 2003, pg 45346	<a href="http://www.cms.hhs.gov/providers/hipps">www.cms.hhs.gov/providers/hipps</a> 42CFR412.308 Subparts A-M
Critical Access (CAH)	Vol. 67, No.164, Friday, August 23, 2002, pg 54657	<a href="http://www.cms.hhs.gov/providers/cah">www.cms.hhs.gov/providers/cah</a> 42CFR413.70
Skilled Nursing (SNF)/Swing Bed (SW)	(SNF) Vol. 64, No. 146, Friday, July 30, 2002, pg 41684 (SW) Vol. 66, No. 147, Tuesday, July 31, 2001 p. 39562	<a href="http://www.cms.hhs.gov/providers/snfpps">www.cms.hhs.gov/providers/snfpps</a> 42CFR410, 411, 413, 424, and 489
Inpatient Rehabilitation (IRF)	Vol. 66, No. 152, Tuesday, August 7, 2001, pg.41316	<a href="http://www.cms.hhs.gov/providers/irfpps">www.cms.hhs.gov/providers/irfpps</a> 42CFR 412 and 413
Inpatient Psychiatric (IPF)	Vol. 68, No. 229, Friday, Nov. 28, 2003 pg 66920 (proposed rule)	<a href="http://www.cms.hhs.gov/providers/ipfpps">www.cms.hhs.gov/providers/ipfpps</a> 42CFR412, 413, and 424
Long Term Care Acute (LTF)	Vol. 69, No. 89, Friday, May 7, 2004, pg. 24674	<a href="http://www.cms.hhs.gov/providers/longterm">www.cms.hhs.gov/providers/longterm</a> 42CFR413, 42CFR412 Subpart O
Hospital Outpatient	Vol. 67, No. 41, Friday, March 1, 2002, pg 9555	<a href="http://www.cms.hhs.gov/providers/hopps">www.cms.hhs.gov/providers/hopps</a> 42CFR413, 419 and 489
Hospital staff physicians	See CMS websites for Medicare Part B procedures and services under the Medicare Fee Schedule Database RBRVS Vol. 68 No 216, Friday, Nov. 7, 2003	<a href="http://www.cms.hhs.gov/physicians/regs#">www.cms.hhs.gov/physicians/regs#</a> 42CFR Part 410 and 414
Hospice	Vol. 68, No. 187, Friday, Sept. 26, 2003	<a href="http://www.cms.hhs.gov/providers/hospiceps">www.cms.hhs.gov/providers/hospiceps</a> 42CFR Part 418
Home Health	Vol. 68, No. 234, Friday, Dec. 5, 2003	<a href="http://www.cms.hhs.gov/providers/hha">www.cms.hhs.gov/providers/hha</a> 42CFR Part 484

To inform Medicare enrolled hospitals and I/T/Us the regulations/guidelines should address the following topics:

1. Explain of how the IHS/Tribal CHS system operates
2. Reflect that under Sec. 506, I/T/Us may negotiate rates that are lower than the Medicare rates

3. Explain that payments are payments in full. (According to Section 222 of the IHCA, patients who receive authorized Contract Health Services are “not liable for the payment of any charges or costs associated with the provision of such services.”)
4. Explain that the CHS program is the payor of last resort. The I/T/U will pay any amount remaining for medically necessary services for which the CHS program has assumed responsibility, after coordinating other patient benefits. The maximum recovery of a Medicare enrolled hospital in any case in which an I/T/U CHS program is a full or partial payor shall be the Medicare-like rates. If the patient is eligible for benefits from Medicare, Medicaid, or another third-party payor, the I/T/U will pay only that portion of the Medicare-like rate not covered by the other payor. When there is more than one other third party payor, the coordination of benefits will be according to industry standards.
5. Explain the basic payment methodology
  - a. With some modifications the I/T/Us will reimburse hospitals for inpatient care according to the most recent Medicare Methodology
  - b. Settled cost reports will be used. Costs considered in the pass-through amount are added to the Diagnostic Related Group (DRG) payment.
  - c. Outpatient prospective payment system methodology will be used for most hospitals
  - d. The hospital staff physicians will be paid the Medicare fee schedule published by Centers for Medicare & Medicaid Services (CMS)
6. Note that no retrospective analysis will be performed. (Since CHS program is subject to an annual appropriation amount, this program cannot accommodate a system that will obligate payments in future years. Plus, the administrative costs to the I/T/U of performing such analysis would far outweigh the benefits.)
7. Discuss using provider specific file from CMS
8. Explain how the CMS pricers will be used.
9. Note that hospital units excluded from the Prospective Payment System (PPS), per CMS, will be paid at a per diem rate
10. Note that if no settled cost reports are available (this is the case for a new hospital), the hospital will be paid as a percentage of billed charges until the provider's Medicare Intermediary supplies appropriate information.
11. Note that for a CHS service that has been approved by I/T/Us for which there is no Medicare rate, the regulations/guidance should provide an alternate methodology such as the Medicaid rate or percentage of billed charges
12. Explain how transfers will be paid (referrals to a Medicare certified facility and referrals to a non-Medicare certified facility).
13. Explain how outliers will be paid.
14. Note that hospitals should submit inpatient, outpatient and physician charges in the same manner as for CMS billing. This includes requiring the Medicare provider number on the CMS1450 and 1500 claim form.
15. Note that hospitals are required to provide, at no cost, requested medical information to I/T/Us for continuity of care and for payment determinations.

16. Note that a hospital may apply to CMS for a waiver of the payment limitations in exceptional circumstances, pursuant to criteria established by CMS. CMS shall assure that I/T/Us affected by a hospital's waiver request receive notice and an opportunity to comment before CMS acts on such request.
17. Note that any hospital which fails to abide by the CMS regulations/guidelines regarding Sec. 506 payment limitations will be subject to CMS enforcement action applicable to violations of the Medicare Agreement.

#### **D. Announcement/Education Documents for Hospitals**

Hospitals should be informed prior to the implementation of Section 506 by CMS. This notification will be provided to I/T/Us. CMS should consult with the Tribal Technical Advisory Group (TTAG) before conducting training.