National Indian Health Board

January 31, 2014

Dr. Yvette Roubideaux, M.D., M.P.H.
Director, Indian Health Service
Department of Health and Human Services
Suite 440, The Reyes Building
801 Thompson Avenue
Rockville, MD 20852-1627

Re: Dear Tribal Leader Letter on December 6, 2013, Medicare Like Rates for non-hospital services

Dear Dr. Roubideaux:

On behalf of the National Indian Health Board (NIHB) and the 566 Federally Recognized American Indian and Alaska Native Tribal Governments we serve, I write in response to your Dear Tribal Leader letter of December 6, 2013, which requested comments on the April 2013 Government Accountability Office (GAO) report titled "Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services" (GAO-13-272) that discussed expansion of Medicare-like rates (MLR) for non-hospital Purchased/Referred Care (PRC) (formally Contract Health Services) at the Indian Health Service (IHS). Firstly, I would like to express our gratitude for your consideration of this important issue and the concurrence of the Department of Health and Human Services (HHS) with the GAO report. ***NIHB strongly supports the expansion of MLR to non-hospital services as soon as possible, and supports a legislative fix pursuant to the recommendations outlined in GAO-13-272.***

PRC funds are historically one of the most underfunded accounts in IHS. The National Tribal Budget Formulation Workgroup's Recommendations on the FY 2015 IHS Budget, recommend a total of $1.1 billion for PRC, but the FY 2014 Omnibus Appropriations Act (P.L. 113-73) funded this account at only $878 million. Though this is an increase over the FY 2013 level, Tribes are still scrambling to recover from the devastating sequestration cuts in FY 2013. Federal discretionary spending is shrinking every year, while medical inflation is growing, and it is imperative that IHS and Tribal health facilities use all means possible to make these dollars go further. The expansion of MLR for non-hospital providers is a critical step in making sure this happens.

As you mention in the December 6 letter, Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), authorized the Secretary of Health and Human Services to require Medicare participating hospitals to accept MLR for PRC from the IHS. Thanks to the ensuing regulations issued in 2007, PRC payments for hospitals are now being paid at lower rates and officials from both IHS and Tribal offices said that "the implementation of the MLR requirement in 2007 allowed the CHS program to reduce payments for hospital services" (GAO-13-272, p. 38). In many cases, the GAO report noted that the requirement for MLR allowed the PRC program to expand access to care and afforded some programs to expand services from Priority I only to Priority I & II cases. This change was clearly a benefit for American Indians and Alaska Natives (AI/ANs) and vital to stretching much-needed PRC dollars further.

In addition, PRC programs are likely the only federal health care programs that continue to pay full billed charges for non-hospital services. Expanding the MLR to non-hospital services, IHS and Tribal PRC

programs would be able to save hundreds of millions of dollars and dramatically increase the care provided through PRC. The Veteran's Administration and the Department of Defense have already capped their rates for non-hospital providers and PRC programs should be authorized to do so as well.

NIHB is consistently concerned about access to care for Tribes located in remote or rural locations. Often, IHS patients must drive hours to receive treatment, which is cost-prohibitive for many. A change of this kind must not inhibit the access to care for AI/ANs. 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 expansion should require that any provider accepting Medicare to also accept MLR for payments billed through PRC programs. As the GAO report points out, most providers and suppliers already participate in Medicare and are accustomed to paying Medicare rates for services.

NIHB echoes the recommendation of the GAO: "Congress should consider imposing a cap on payments for physician and other nonhospital services made through IHS's [Contract Health Service] program that is consistent with the rates paid by other federal agencies" (GAO-13-272, p. 43). Specifically, we recommend amending Section 1866 of the Social Security Act in order to ensure full compliance all providers. By enacting a statutory measure and an ensuing regulation, as was done with the PRC cap for hospitals, providers accepting Medicaid would not be able to deny these rates. While some IHS and Tribal health providers are already negotiating lower rates for non-hospital providers, a statutory requirement would mean that all of Indian Country could benefit from these lower rates.

NIHB is engaged in a coalition with other Tribes and Tribal organizations to educate Members of Congress on the importance of this fix. We believe that there is currently a serious effort to move legislation on this matter. Recent conversations with Members of Congress and their staff indicate that legislation will be introduced soon, and then move quickly through the legislative process. NIHB would welcome the Administration's continued support of this policy adjustment.

Again, on behalf of NIHB, I would like to express my gratitude for your consideration of this important matter and the support of HHS for the GAO report's recommendation. Expansion of MLR for PRC to non-hospital services will be critical in improving the care that AI/ANs receive through the IHS/ Tribal health care delivery system.

Should you have any questions on this matter, please contact NIHB Executive Director Stacy Bohlen at (202) 507-4070 or sbohlen@nihb.org. Thank you very much for your attention to this matter.

Sincerely,

Cathy M. Abramson

Cathy Abramson
Chairperson