United South and Eastern Tribes, Inc.

Nashville, TN Office:
711 Stewarts Ferry Pike, Suite 100
Nashville, TN 37214
Phone: (615) 872-7900
Fax: (615) 872-7417

Washington, DC Office:
400 North Capitol Street, Suite 585
Washington, D.C., 20001
Phone: (202) 624-3550
Fax: (202) 393-5218

USET Praises Introduction of Native CARE Act

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For more information please contact:
Brandon Stephens, Development Director
(615) 467-1560
bstephens@usetinc.org

This week, Reps. Betty McCollum (D-MN) and Tom Cole (R-OK), along with other Members of Congressional Native American Caucus leadership, introduced H.R. 4843, The Native Contract and Rate Expenditure (CARE) Act of 2014. A response to strong advocacy from USET, the National Indian Health Board, and other Tribes and Tribal organizations, this long overdue, common sense legislation will allow the Indian Health Service (IHS) and Tribal Purchased/Referred Care (PRC) (formerly Contract Health Service) programs to provide hundreds of thousands of additional health care services to American Indian and Alaska Native (AI/AN) patients annually at no additional cost to the federal government.

"We are thrilled that our champions in Congress continue to support innovative ways to protect and improve health care for American Indians and Alaska Natives," said Lynn Malerba, Chief of the Mohegan Tribe and Chairwoman of IHS' Tribal Self-Governance Advisory Committee. *"'Don't get sick after June' remains an all-too-common refrain throughout Indian Country, because this is typically the month Tribal clinics run out of funding and have to reduce, postpone, or stop providing services. The Native CARE Act could change that, by allowing our overtaxed PRC programs to dramatically increase the amount and types of services that patients receive, bringing the Indian Health System closer to parity with the rest of American health care," Chief Malerba continued.*

The PRC program, as well as other items in the IHS budget, is chronically underfunded and usually runs out prior to the end of the fiscal year which leads to the denial or deferral of hundreds of thousands of necessary health care services for American Indians and Alaska Natives annually. A major cause of this shortfall is the rate the Indian Health System pays for outside care. In 2013, a Government Accountability Office (GAO) report found that while federal healthcare providers like the Veterans' Administration, Medicare, Medicaid, as well as private insurers pay only a fraction of what providers charge, the IHS and Tribes, who routinely pay full billed charges for non-hospital care, up to 70% more on average. The GAO report states that if the Indian Health System paid a "Medicare-Like" rate for purchased services, IHS and Tribal PRC programs would save millions of dollars, resulting in an estimated 253,000 additional physician services for AI/AN patients annually.

The Native CARE Act amends the Social Security Act to expand the Medicare-Like Rate cap beyond hospitals to cover all Medicare-participating providers and suppliers. It will ensure that AI/ANs have continued access to health care providers by making it a requirement for all Medicare-participating providers and suppliers, including physicians, to accept this rate of payment as payment in full as a

condition participating in the Medicare program. This payment reform is achieved without additional cost to the federal government.

"It's simple. The IHS should pay the same rates as all other federal entities for the same care," said USET President, Brian Patterson. "*It is a more efficient use of federal dollars and more importantly, it enhances the level of care our people receive. We thank the Native American Caucus for sharing our vision of a healthier future for Native people. We urge Congress to act swiftly on this legislation."*

The Native Care Act (H.R. 4843) has been referred to the House Energy and Commerce, Ways and Means, and Natural Resources Committees, where it awaits further action. A Senate companion bill is expected to be introduced shortly.

USET and the National Indian Health Board have compiled additional background and frequently asked question information, which has been included with this announcement.

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National Indian Health Board

JUNE 6, 2014

MEDICARE LIKE RATES FOR ALL CARE PURCHASED BY THE INDIAN HEALTH SERVICE

Request

Support H.R. 4843, "the Native Contract and Rate Expenditure (CARE) Act'' which would extend the Medicare-like rate cap on payments made by Purchased/ Referred Care (PRC) (formerly Contract Health Services) programs at the Indian Health Service (IHS) and Tribal levels to all Medicare participating providers and suppliers.

Background

American Indians and Alaska Natives (AI/ANs) suffer disproportionately from a variety of health afflictions including diabetes, heart disease, tuberculosis, and cancer. Compounding these health issues is the lack and untimeliness of resources for health care delivery services in Tribal communities. The IHS continues to be chronically underfunded with a budget that only meets 59% of need. Put another way, in 2013, the IHS per capita expenditures for patient health services were just $2,849, compared to $7,717 per person for health care spending nationally. One of the most chronically under-funded accounts is the PRC program, which the Indian Health Service and tribal health programs use to purchase healthcare services from outside providers when necessary. With the continuing likelihood of flat or reduced funding, Tribes are seeking alternative ways to make these precious dollars go further.

In 2003, Congress sought to make PRC program dollars go further by amending the Medicare law to authorize the Secretary of Health and Human Services to establish a cap on the rate PRC programs must pay hospitals for the services they provide to AI/ANs referred under the PRC program. That rate was established as the "Medicare Like Rate." However, hospital services represent only a fraction of the services provided through the PRC system. PRC programs routinely pay full billed charges for non-hospital services, including physician services. On average this is up to 70 percent more than would be paid by Medicare, and other federal and private payers. As a result, the PRC program continues to run out of funds each year, with 147,000 services denied in FY 2013.

In a report issued on April 11, 2013,[1] the Government Accountability Office (GAO) concluded "Congress should consider imposing a cap on payments for physician and other nonhospital services made through IHS's [PRC] program that is consistent with the rate paid by other federal agencies." The GAO report concluded:

- Federal PRC programs paid non-contracted physicians two and a half times more than what it estimates Medicare would have paid for the same services.
- Expanding the Medicare-Like Rate cap would allow the IHS to provide approximately 253,000 additional physician services annually.
- Expanding the Medicare-Like Rate Cap would have resulted in hundreds of millions of dollars in new federal health care resources being made available to AI/ANs in 2010 alone.

The Proposed Legislation:

The proposed legislation would amend the Social Security Act to expand the Medicare-Like Rate cap to cover all Medicare-participating providers and suppliers. It will ensure that AI/ANs have continued access

to health care 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.

[1] GAO-13-272: "Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services," April 11, 2013.

What is purchased/referred care?

The purchased/referred care (PRC) program pays for urgent and emergent and other critical services that are not directly available through IHS and Tribally-operated health programs when:

1. No IHS direct care facility exists,
2. The direct care facility cannot provide the required emergency or specialty care, or
3. The facility has more demand for services than it can currently meet.

The PRC budget supports essential health care services from non-IHS or non-Tribal providers and includes inpatient and outpatient care, emergency care, transportation, and medical support services such as diagnostic imaging, physical therapy, laboratory, nutrition, and pharmacy services. These funds are critical to securing the care needed to treat injuries, cardiovascular and heart disease, diabetes, digestive diseases, and cancer, which are among the leading causes of death among American Indians and Alaska Natives. At current funding levels, many IHS and Tribally operated programs are only able to cover Priority I[2] services to preserve life and limb and are often unable to fully meet patients' needs at even this restrictive PRC service category. Because PRC is only treating the most desperate of cases at current funding levels, any shortfall in the program correlates to increased death rates for communities in Indian Country. Failure to pay PRC claims also means that patients are often given only symptomatic treatment, leading to long-term pain management, worse health outcomes and increased costs to the Indian health delivery system.

What rates to other federal health providers pay?

The PRC program may be the only program in the federal government that pays rates above the Medicare rate. Neither the VA nor the DOD 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.

How will this change affect physicians?

Under the proposed legislation, if a provider refused to accept that rate of payment, they would no longer be eligible to participate in the Medicare program. However, because AI/ANs make up less than two percent of the total demand for care nationally, and, because most providers and suppliers are currently accepting Medicare rates for many services, the proposed legislation is not likely to impact existing providers and suppliers in a big way. The 2013 GAO study did not find evidence that providers would be widely affected by this change.

What will H.R. 4843 cost?

The proposed legislation is budget neutral and consistent with federal policy. It 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. Instead, it would allow appropriated dollars to be used more effectively and efficiently.

What is the Administration position?

The Administration concurred in the GAO report and has formally supported this legislative change in its FY 2015 Budget Request for IHS.

[2] For a breakdown of IHS Medical Priority Levels see:

http://www.ihs.gov/chs/index.cfm?module=chs_requirements_priorities_of_care