

National Indian Health Board



JANUARY 13, 2015

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

Request

Support legislation that would provide for the extension of 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.

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 I² 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?

Because AI/ANs make up less than two percent of the total demand for care nationally, 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