Medicine Dish Broadcast
November 14, 2007
"Medicare 101 for Indian Health Providers"

BLOCK 1
Introduction - Welcome / Introduction to Medicine Dish broadcast "Medicare 101 and Providers"

Welcome to
Medicine Dish.
I'm Dorothy Dupree
your host.
Today's program will provide
a brief overview
of the
legislative authority
extended to
Indian health providers
as well as an overview of Medicare
program specifics applicable to Indian
health providers.
We are also joined by a representative
of the
Indian Health Service

with valuable information specific to their health programs.
Thank you for joining us, and I'm looking forward
to you,
members of our viewing audience, joining us with your questions ...

all this and more on this installment of Medicine Dish.

[30 Second roll-in video]

BLOCK 2
Introduction to Panel and Topic

I want to welcome you to our November **Medicine Dish** broadcast.
Our topic today is
Medicare 101.
Our panel today
will be providing you an overview of Medicare as the program relates
to Providers.
Our Panel is comprised of:

- Terri Harris,
Health Insurance Specialist, CMM ...

- Paula Hammond, Technical Advisor,
Medicare Fee for Service Branch, Region VI ...

- and
Elmer Brewster,
Indian Health Service.

The Panel will provide a brief overview of the Medicare Program
and provide information pertinent to Indian Health providers.

Should you have questions during this Medicine Dish presentation,
you can contact us during this broadcast by following one of two options:

1. You can call the
800 # listed on your screen and ask your question live **-or-**

2. You can fax your question to

410-786-0123
and the panel will be asked to respond.

Now I'd like to turn
the mike over to our first panelist,
Terri Harris,
who will provide
a brief overview of changes to Medicare legislation that have impacted Indian care health programs over the last several years. Terri is with the
Centers for Medicare Management, and was introduced to the world of Indian health in 2000 when we began working on the implementation of BIPA 432.
She's a great resource, and I'm happy she's able to join us today.

Terri ...

BLOCK 3
Medicare Legislative Overview

Terri:
Thank you, Dorothy. It's been quite an experience for me to learn about

Indian health
and the system of care established to serve the American Indian and Alaska Native population. I've learned a tremendous amount over the years, and have enjoyed the opportunity very much.

[To the camera]

The United States government has a historical and unique legal relationship with, and resulting responsibility to Tribal governments and the American Indian and Alaska Native population.
A major goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level, and to encourage maximum participation of Indians in the planning and management of those services. The health care delivery system for tribes with this unique government-to-government relationship consists of Indian Health Service owned and operated healthcare facilities ...

Indian Health Service owned facilities
that are operated by Indian tribes or tribal organizations under
638 agreements,
which consist of contracts,
grants,
or compacts ...

and facilities owned and operated by tribes or tribal organizations under such agreements.

The IHS is the primary health care provider to the American Indian and Alaska Native Medicare population. The Indian health care system,
consisting of tribal,
urban,
and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries via a network of hospitals,
clinics,
and other entities.

SLIDE # 1

While sections 1814(c) and 1835(d) of the Social Security Act generally prohibit payment to any
Federal agency,
an exception is provided for IHS facilities under section 1880 of the Social Security Act.
The passage of the Indian Health Care Improvement Act
in 1976 provided for an exception for facilities of the IHS whether operated by IHS,
Indian tribes,
or tribal organization.

SLIDE # 2

Effective July 1, 2001, section 432 of the Benefits Improvement and Protection Act, known as BIPA, extended payment to services of physician and non-physician practitioners furnished in hospitals and ambulatory care clinics. This meant that clinics associated with hospitals and

freestanding clinics that are owned and operated by IHS, or that are tribally owned but
IHS operated,
are considered to be IHS, and are authorized to bill Medicare for
Part B services identified in section 432 of BIPA. This legislation opened up a new billing authority and allowed many Indian health care providers to seek Medicare reimbursement payable under Part B by Medicare carriers.
It had one distinct limitation in that it applied only to services which were payable under the physician fee schedule.

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act. The Social Security Act requires that payments under the fee schedule be based on national uniform relative value units that reflect the relative resources required to perform each service.
Section 1848(c) of the Social Security Act requires that national uniform relative

value be established for physician work, practice expense, and malpractice expense. The Medicare physician's fee schedule proposed regulation
is usually published
in the Federal Register
in the month of July with the final regulation published in the month of November.
For calendar year 2008 the medicare physician fee schedule
will be published in the Federal Register November 27th.

SLIDE #3

Effective January 1, 2005,
another legislative change through the 2003 Medicare Modernization Act, known as MMA,
further broadened the scope of services for which Indian Country providers could bill Medicare. It allowed IHS facilities to bill for other Part B services which were not covered under section 1848 of the Social Security Act.

SLIDE # 4

The MMA section 630 expanded the scope of items and services for which payment may be made to
IHS facilities and other suppliers
in the IHS system
to include all other
Part B covered items. This completed the missing piece from the BIPA section 432, and allowed Indian health care providers to bill for the full range of Medicare Part B covered services. However,
this authority is only for a 5 year period of time, beginning
January 1, 2005,
and ending
December 31, 2009.

I hope this has been helpful.
A team of Medicare
staff is involved
in the administration
of the services paid for by Medicare.
It can be daunting when seeking out

assistance on any particular issue.
You can always contact your Native American Contact in each Regional Office, or the Tribal Affairs Group at
Central Office
[slide # 9]
or you can find detailed information concerning Medicare payments to Indian Health Service facilities
at the resources you see on screen:

www.cms.gov
manuals
Internet Only Manuals (IOMs)
Pub. 100-04
Chapter 19 – Indian Health Services.

Thank you for your time, and now
I'll turn this back to Dorothy.

BLOCK 4
1:45 – 1:46

Dorothy:
Thank you, Terri.

I'd like to
take a moment
to introduce you, our viewing audience,
to an important Medicare resource
available to
help providers understand
our program -
the CMS Medicare Learning Network
(MEDLearn).
Recently,
we received feedback from
one of the IHS administrative staff on the
usefulness of the NPI article, one of the
articles published by the Medicare
Learning Network.
This article is
one of many educational products
published by the MEDLearn Matters staff.
Let's take a moment to hear more about
this important resource in the following
video.

[ROLL PSA Video - Puzzled by Medicare]

BLOCK 5

Transition and introduce Paula

Our next panelist is Paula Hammond.

Paula is a
Technical Advisor working in the Medicare program in Region VI.

Paula is extremely knowledgeable about Medicare and Indian health programs, and is one of the first people that I turn to whenever I need technical assistance. Today, Paula will be providing an overview of Medicare and what Providers need to be aware of.

BLOCK 6
Background

The Indian Health Service is the primary health care provider to Medicare beneficiaries who are members of federally recognized tribes.
The Indian health care system, consisting of tribal,
urban,

and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries via a network of acute care hospitals, including Critical Access Hospitals, or CAHs ...

freestanding physician-directed clinics ...

Federally Qualified Health Centers,
or FQHCs ...

Rural Health Centers,
or RHCs ...

and other entities.

Sections 1814(c) and 1835(d) of the Social Security Act generally prohibit payment to any federal providers of services or other Federal Agency. However, passage of the Indian Health Care Improvement Act in **1976** provided for an exception, amending 1880 of the Act, for facilities of the IHS whether operated by IHS,

an Indian tribe,
or tribal organization as defined in Section 4 of the Indian Health Care Improvement Act.
That exception under Section 1880 of the SSA limited payment to Medicare services provided in hospitals and skilled nursing facilities.
For many years, TrailBlazer Health Enterprises,
has functioned
as the designated
fiscal intermediary
for these services.

Section 13556 of the Omnibus Budget Reconciliation Act, or OBRA,
of 1993 amended
Section 1861(aa)
of the
Social Security Act by adding payment for outpatient health programs or facilities operated by a tribe
or tribal organization
under the Indian
Self-Determination Act, or by an urban

Indian organization receiving funds under Title V of the Indian Health Care Improvement Act,
as entities eligible to participate in Medicare as Federally Qualified Health Centers
known as FQHCs.
All FQHC claims are processed by National Government Services,
formerly
United Government
Services.

Effective
July 1, 2001, legislative changes made through the Medicare,
Medicaid,
and S-CHIP Benefits Improvement and Protection Act of 2000,
or BIPA,
expanded the scope of services for which Indian Country providers could bill Medicare.

Section 432 of BIPA
extended payment on a fee-for-service

basis to services of physician and non-physician practitioners furnished in IHS hospitals and freestanding clinics that are owned and/or operated by IHS.

This meant that clinics associated with hospitals or freestanding clinics that were owned and operated by IHS, or that were tribally owned but IHS operated, were considered to be IHS, and were authorized to bill the designated specialty carrier for Indian Country, TrailBlazer.

Other clinics associated with hospitals and freestanding clinics that were not considered to be IHS, for example, IHS owned but tribally operated, or tribally owned and operated, could continue to bill their local Part B carrier for the full range of covered Medicare services,

and were not restricted to the limitations of the BIPA provision.
This legislation opened up a new billing authority, and allowed many Indian Country providers to seek Medicare reimbursement payable under
Part B by
Medicare carriers.

It had one distinct limitation in that it applied **only** to services which were payable under the physician fee schedule, Section 1848 of the
Social Security Act.

Effective
January 1, 2005, another legislative change through the 2003 Medicare Modernization Act,
or MMA,
further broadened the scope of services for which Indian Country providers could bill Medicare.
Section 630 of MMA allowed IHS facilities to bill for **other** Part B services which were not covered under 1848 of the Act.

MMA 630 expanded the scope of items and services for which payment may be made to IHS
facilities and other suppliers in the IHS system to include all other Part B covered items and services for a 5 year period beginning
January 1, 2005.

I would like to point out that payment for services under MMA 630
sunsets or ends, effective
December 31, 2009,
unless legislative action occurs.
This completed the missing piece from BIPA 432 and allowed Indian Country to bill for the full range of Medicare Part B covered services. IHS operated entities will bill the designated carrier, TrailBlazer, for covered Part B services.
Tribally operated providers have a choice to bill either their local carrier or the designated carrier, TrailBlazer, for covered Part B services.
However,
they are prohibited from billing both

entities.

Services added by MMA 630 are:

- ambulance services

- clinical laboratory services

- drugs processed by the DME Medicare Administrative Contractor,
or DME MAC

- flu and pneumonia injections

- durable medical equipment/supplies

- prosthetics/
orthotics

- prosthetic devices

- surgical dressings, splints, and casts

- and screening and preventive services not already covered.

CMS Instructions

On August 25, 2006,
CMS issued "Chapter 19, Indian Health Services," under "Publication 100-04 -
Medicare Claims Processing"
of the agency's Internet Only Manual.
A copy of this instruction can be located on the CMS website at:

www.cms.hhs.gov/
manuals/downloads/clm104c19.pdf

The transmittal number was 1040 and the change request number was 5230.

This was an effort by CMS to delineate a number of special guidelines or instructions
that are unique to Indian Country.

Services Paid By Fiscal Intermediaries

Acute Hospitals –
Inpatient services provided in IHS

hospitals are paid according to the inpatient hospital prospective payment system based on diagnosis related groups, or DRGs,
just like regular Medicare hospitals. The only difference is that IHS hospitals receive a slightly higher DRG, based off a higher wage index.

The PPS Pricer System recognizes IHS hospitals as provider type 08. Inpatient hospital services are paid by Medicare Part A trust fund monies and claims are submitted via
UB-04,
or electronic equivalent,
to the designated fiscal intermediary, TrailBlazer.

Although IHS acute care hospitals are currently exempt from traditional cost reporting requirements,
they do prepare and submit to CMS each year a modified Method E cost report which is used to calculate the all-inclusive rate,

or AIR,
for reimbursement of **outpatient hospital services**.

Since they are paid the AIR,
outpatient services provided in
IHS hospitals
are not subject to the Outpatient Prospective Payment System, or OPPS.
The AIR for outpatient services is updated annually using data from the submitted cost reports,
approved by the Office of Management and Budget,
and published in the federal register each year.
Upon release of the notice in the federal register, CMS issues instructions to the Medicare fiscal intermediary to begin using the new rates with the appropriate effective date,
and to process any necessary claim adjustments.
Claims for outpatient services are submitted via UB-04,
or electronic equivalent,

to TrailBlazer. Payment of outpatient hospital services comes from Part B trust fund monies. Hospital ambulance services are reimbursed based on the ambulance fee schedule.

Outpatient Hospital Services – These services have been briefly addressed above which are payable through the AIR. However, the following services are billed **outside** the AIR:

Service / Revenue Code

- Orthotics/ Prosthetics
  - 0274

- Influenza/ Pneumococcal
  - Administration - 0771

- Pneumonia/ Hepatitis B

- Vaccine – 0636

- Ambulance
- 0540

- Physical Therapy - 0420

- Occupational Therapy
- 0430

- Speech-Language Pathology
- 0440

- Surgical Dressings
- 0623

Skilled Nursing Facility (SNF) or SNF Swing Bed Services in IHS Hospitals – Effective July 2002, IHS SNFs or hospital SNF swing-bed services began being paid according to the SNF Prospective Payment System (SNF PPS). Currently, there are no free-standing IHS SNFs but a few hospitals do have some designated SNF swing-beds. Payments for these inpatient services are made from the Part

A Medicare Trust Fund and services are billed on the UB-04 claim form (or electronic equivalent).

- **Critical Access Hospitals (CAHs)** – IHS CAHs are paid 101 percent of an all-inclusive **facility specific** per diem rate for covered inpatient services on or after January 1, 2004.

This payment rate is different than the outpatient AIR.

An average of
96 hours of acute inpatient care in a CAH shall be paid by Medicare
Part A.

CAH inpatient swing-bed services are exempt from SNF PPS,
and instead,
are paid at
101 percent of an all-inclusive facility specific per diem rate.

CAH outpatient services are paid at 101 percent of an all-inclusive facility specific visit rate.

CAH ambulance services are paid at the ambulance fee schedule unless they meet the 35-mile criteria and qualify for

100 percent,
not 101 percent,
of reasonable cost.

CAHs file Method E
cost reports are
used to set the
facility specific rates for the coming year.

- **Federally Qualified Health Centers (FQHCs)** –
Freestanding FQHCs are paid on a facility specific FQHC encounter rate, not to exceed a national cap amount.
There is a different national cap amount for urban vs. rural centers and these amounts are updated annually.
Outpatient health programs or facilities operated by a tribe or tribal organization under the Indian
Self-Determination Act or by an urban Indian organization receiving funds under Title 5 of the Indian Health Care Improvement Act can qualify to be FQHCs.
Clinics can be located in rural or urban areas to meet the health needs of

medically underserved populations.
FQHC services include the same services as RHCs plus a set of preventive services.
All FQHCs, including tribal FQHCs, currently enroll with National Government Services,
which is the national fiscal intermediary for all FQHC claims. FQHC services are billable via the
UB-04 claim form,
or electronic equivalent,
and payments are made from the Medicare Part B Trust Fund.
FQHCs file a full annual cost report which is subject to audit and cost settlement, and is used to set the encounter rates for the following year.
The completion of the full cost report is much more extensive than the Method E cost report used to calculate the AIR for outpatient hospital services.
Freestanding FQHCs must also enroll with the
Part B carrier to file via CMS-1500 claim form,
or electronic equivalent,

or non-FQHC services,
which are the same as non-RHC services.

- **Rural Health Clinics (RHCs)** –
Freestanding RHCs are paid based on a facility specific RHC encounter rate, not to exceed a national cap amount that is updated annually. RHC services include those of a physician,
nurse practitioner, physician assistant,
certified nurse midwife,
clinical psychologist,
and clinical social worker.

Visiting nurse services can also be provided in areas where the State Agency confirms there is a shortage of home health agencies. These services are billable via the
UB-04,
or electronic equivalent,
to the Regional RHC fiscal intermediary, and payments are made from the Medicare Part B Trust Fund.
RHCs file full annual cost reports that are subject to audit and cost settlement,

and are used to set encounter rates for the following year. Freestanding RHCs must also enroll with the Part B carrier to file via CMS-1500 claim form, or electronic equivalent, for non-RHC services such as lab, technical components of diagnostic tests, and physician and practitioner services provided in hospital settings. The non-RHC services are also paid from the Medicare Part B Trust Fund.

Services Paid by Carriers

Physicians and Nonphysician Practitioners - This includes physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical social workers, clinical psychologists, medical nutrition professionals, and certified registered nurse anesthetists.

These providers are all reimbursed under the Physician Fee Schedule,
except for CRNAs which are reimbursed under the anesthesia fee schedule.

Physician Assistants,
Nurse Practicioners,
Clinical Nurse Specialists,
and Medical Nutrition Professionals are reimbursed 85%
of the physician fee schedule. Clinical psychologists are reimbursed at
100% of the physician fee schedule, similar to physicians.

Clinical social workers are reimbursed at 75% of the fee schedule,
and certified nurse midwives are reimbursed at
65% of the
fee schedule.

If these services are provided in an IHS hospital-based outpatient clinic, they are separately payable from the AIR,
and claims are submitted to the

designated carrier, TrailBlazer.
Free-standing IHS physician directed clinics can also bill the designated carrier, TrailBlazer, for the full range of services that are billable in a physician's office.

Tribal 638 physician directed clinics may either bill their local carrier,
or the designated carrier,
but not both. Incident-to services and supplies, such as injectable drugs, provided by auxiliary staff working under the direct supervision of physicians,
Physican Assistants,
Nurse Practicioners, Clinical Nurse Specialists,
Certified Nurse Midwives,
and Clinical Phsychologists
can also be included on the Part B carrier claims when provided in the freestanding clinic setting. In the hospital-based clinic environment, these incident-to services are included on the hospital's bill to the Fiscal Intermediary not on the physician or practitioner bill
to the carrier.

- **Ambulance Suppliers** –
Free-standing IHS ambulance suppliers would enroll with the designated carrier, Trailblazer, and would submit claims via CMS-1500,
or electronic equivalent. Reimbursement is based on the ambulance fee schedule. Tribal ambulance suppliers may enroll with the designated carrier or local carrier. However,
hospital-based ambulance suppliers do not bill the carrier for their services. These services are billed to the designated intermediary, TrailBlazer via
UB-04 claim form,
or electronic equivalent.

- **Clinical Laboratory Services** –
Medicare Part B payment may be made to freestanding facilities for covered clinical lab tests as a result of MMA 630. Payment is based on the clinical laboratory fee schedule.

- **Durable Medical Equipment**

Suppliers – Medicare Part B payment may be made for covered DME, prosthetics, orthotics, and supplies to IHS or tribal suppliers that furnish DME for use in the beneficiary's home. Hospitals can make DME available upon discharge for use in the patient's home and available for use by the patients seen in the hospital's outpatient clinics.

While DME is **NOT** covered for inpatients, hospitals can bill the DME Medicare Administrative Contractor for DME provided on an outpatient basis as just described. In such cases, the hospital would need to contact the National Supplier Clearinghouse, obtain a DME supplier number, and bill the appropriate DME Medicare Administrative Contractor. Certain oral self-administered drugs are also reimbursed by the DME Medicare

Administative Contractor: immuno-suppressive drugs,
oral anticancer,
and oral antiemetic drugs.
If a facility decides to bill for items
on the DME fee schedule, they will have to enroll as a DME supplier through the National Supplier Clearinghouse,
and bill the appropriate
DME Medicare Administrative Contractor for their service area.

- **Therapy Services** – covered physical therapy, occupational therapy,
and speech pathology services are
payable by the designated carrier or local carrier,
as appropriate. Therapy services are paid based on the Physician Fee Schedule,
and are currently legislatively capped as of January 1, 2006
at $1,780 for physical/
speech therapy, and $1,780 for occupational therapy
in outpatient settings.
The cap does not apply to therapy

services provided in a hospital setting. These services are billed to the hospital's Fiscal Intermediary, TrailBlazer.
The above list of providers or services is not intended to be an all-inclusive list but represents the most common services billed by Indian Country to Medicare. For a complete list and detailed instructions or assistance, providers should refer to the Chapter 19 CMS instructions or their appropriate Medicare intermediary or carrier.

Resource or Educational Information

Centers for Medicare and Medicaid Services

Home Page – www.cms.hhs.gov
Medicare Claims Processing Internet Only Manual,
Chapter 19
Indian Health services –

www.cms.hhs.gov/manuals/downloads/clm104c19.pdf

Medicare Learning Network – www.cms.hhs.gov/medlearn/matters

Correct Coding Initiative, or CCI Edit Information –

www.cms.hhs.gov/physicians/cciedits/default.asp

E&M Documentation Guidelines - www.cms.hhs.gov/MLNEdWebGuide25_EMDOC.asp

TrailBlazer Health Enterprises
Home Page -

www.trailblazerhealth.com

Under the home page, you will see a separate listing for IHS under
Part A and Part B provider sections. You are encouraged to sign up for TrailBlazer's

listservs which are specific to Indian Country issues especially if they are your servicing intermediary or carrier.
Part A Indian Health Provider Customer Service Fiscal Intermediary,
Trailblazer

Phone Inquiries – 888-763-9836, Monday – Friday from 9am -3:30pm CST
E-Mail inquiries – ihs.parta@trailblazerhealth.com

Part B Indian Health Provider Customer Service (carrier)
Phone Inquiries including Requests for Redetermination – 866-448-5894, Monday – Friday from 8:00am – 4:00pm CST
E-Mail inquiries – regular Part B e-mail box at partbtx@trailblazerhealth.com Indian Country inquiries directed to the regular Part B e-mail box are segregated as an IHS inquiry and forwarded to IHS customer service representatives for handling.

Provider Education and Training

In addition to their regular provider education workshops, TrailBlazer offers a number of computer-based training modules including one specifically developed for CAHs. Provider specific manuals, for example, ambulance services are downloadable from TrailBlazer's website.

The opportunity for web-based training is another viable option.

The TrailBlazer Web-based Training Center is a live, interactive, and virtual learning program that allows participants to communicate with a Medicare Representative during training sessions. It is a cost effective, time-saving training method that enables Medicare Provider Outreach and Education staff to conduct large or small computer-based training workshops via the Internet. Some providers desire

special
one-on-one provider training. These types of training are not included in the CMS Scope of Work because of limited budget funds.
However, TrailBlazer does offer Special Training Requests when a facility has agreed to reimburse expenses
for IHS Provider Education representative(s) to provide individual site training if there will be more than 25 attendees.

This is quite a bit of information to absorb in such a short time but please remember that you have these resources
to relay on.
Thank you for your time.
And now I'll turn it back to Dorothy.

Block 7
PSA minute

Thank you, **Paula**.
You presented a great deal of information and I want to remind viewers that they

can download your presentation from the CMS and NIH websites.

We're closer to that portion of our agenda where you will be able to phone or fax your questions to our experts. To give you time to gather your questions regarding this last segment, let's turn our attention to this important "Medicare Preventive Services" announcement.

[ROLL PSA VIDEO
Preventive Services for Indian Country]

Block 8
Indian health programs provide a great deal of preventive health services and it's important to remember those that are reimbursed by Medicare.

(Transition to Elmer)

OK -
let's quickly move on to our next panelist, Elmer Brewster, whom most, if not all of

you, know. CMS works closely with the Indian Health Service in all we do related to Medicare. Elmer has been a strong advocate for increasing access to services for our Indian people and we're pleased that he could join us today. Elmer …

Block 9

Thank you, Dorothy.

Medicare is definitely important to the IHS and Tribes. First, is the importance of the Medicare program to IHS beneficiaries in increasing access to health care and secondly, the Medicare Program provides reimbursements to IHS for providing care to Medicare patients.
I also want to share with you
the enrollment categories of Medicare patients in the IHS and ask that you follow-up to make sure our patients are taking advantage of all alternate resources.

The reimbursements from the Medicare

Program,
Part A, B and D, are critical to maintaining the IHS health care delivery system
at its current levels.
Similar to other alternate resources that we use such as Medicaid, SCHIP,
and Private Iinsurance,
for most of the Inpatient and Ooutpatient services provided to enrolled Medicare beneficiaries,
the IHS
receives payments for these services.
This revenue is used to maintain accreditation of our facilities, and these reimbursements, along with congressional appropriations, helps pay for provider staff in our facilities such as Doctors, nurses, and pharmacists.
The IHS collects over 150 million dollars from Medicare,
and these dollars are vital to the operation of
46 hospitals and over 100 outpatient clinics. Overall,
funds from
third-party resources represent up to

50% of the operating expenses at our hospital and clinics.

In addition, the Medicare program pays for services for beneficiaries who must receive care outside of IHS for emergencies or Contract Health Service referrals to specialty hospitals and physicians.
As we know,
the CHS funds
are limited, especially the last quarter of the fiscal year.
So,
Medicare payment for these referral services is very important because it saves CHS funds that can be used for additional services for patients who may not have a third party payer such as
Medicare,
Medicaid,
or S-CHIP.

Now let me review the Medicare enrollment categories
and the numbers:

[Insert Slide]

This slide provides a snapshot of our patients enrolled
in the Medicare program.
As you can see, our Medicare patients have various combinations of third-party coverage.
About 20% are dual-eligables, those with Medicare and Medicaid.
Almost one third have Medicare Parts A & B,
plus private insurance,
and about
one-third
have only
parts A & B.
One category that needs your
follow-up are those patients that are 65+ and have no insurance whatsoever.
I would like you to compare this information to what you have on the local level,
and please send me any questions or comments.

Lastly,
if you have any questions
about Medicare
in general,
we work with CMS to provide training in each of our Areas. You can contact your local IHS or tribal business offices who are available to answer your questions. CMS also has a network of Native American Contacts in each of their Regional Offices available to assist you.

Now - let me ask you a question …

Have you ever heard of Resource Smart? Take a minute to listen to the next Medicine Dish Minute from my co-worker,
Balerma Burgess.

Block 10
"Resource Smart"

[ROLL PSA VIDEO
Resource Smart]

Block 11

Dorothy:
That's a great message, Elmer.
The Resource Smart message, and the new CMS enrollment video ...

"Our Health -
Our Community" ...

that we showed on our program last month will compliment each other greatly in
building awareness and increasing enrollment for those we serve.

Now it's that time
we move to that segment where we open the phones and faxes to you, our audience.

As a reminder, you have two options as to how you can contact us:

1. You can call
1-800-953-2233 and ask your questions

live **- or -**
2. You can fax your questions to 410-786-0123.

If we don't know the answer, we'll take your contact information and get back to you.

Block 12
Medicine Dish Minute

I want to encourage you to take advantage
of the opportunity
to talk with our experts.
For this,
we will provide you
a brief moment
to get to your phones and faxes in order to ask the experts
your questions.

We'll take a short break for this brief message regarding Diabeties.

[ROLL PSA VIDEO

Future Generations]

Block 13

Welcome back!
So far, we've provided
a brief legislative history of Medicare authority
as it's been extended to Indian health ...

an overview by Paula
of Medicare as it relates to Indian health programs ...

and we've heard from the Indian Health Service.

We'd now like to open our telephones and faxes to you our audience.
This is your time to ask today's panel about Medicare.

1. You can call
1-800-953-2233
and ask your questions live **or**
2. You can fax your questions to 410-

786-0123.

Block 14
CALL-IN PLANT

Questions: Time fillers:

Identify FAQ questions to ask, during Tuesday's group meeting

Block 15
End of Program

Well, we're at the end of our Medicine Dish hour and I and the Panel want to thank you for your participation in our broadcast on Medicare.
I want to take this opportunity to remind you that our next Medicine Dish broadcast will be on
December 12, regarding Medicaid.

I want to remind you that you can access previous broadcasts of our Medicine Dish programs at either
www.cms.hhs.gov/

American Indian/
Alaska Native

- or -

http://videocast.nih.gov/

Thank you,
and I hope you enjoyed and benefited
from today's ***Medicine Dish*** hour.
I'm Dorothy Dupree, your host of
Medicine Dish,
wishing you a very productive day!