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Arizona Hospital and Healthcare Association

June 26, 2006

Ms. Betty Gould
Regulations Officer
Division of Regulatory Affairs,
Records Access, and Policy Liaison
Indian Health Service
801 Thompson Avenue, Suite 450
Rockville, Maryland 20852

Re: Comments to Proposed Rule: Limitation on Charges for Services Furnished by Medicare Participating Inpatient Hospitals to Indians

Dear Ms. Gould:

On behalf of the Arizona Hospital and Healthcare Association ("AzHHA"), thank you for the opportunity to comment on the Indian Health Services' ("IHS") and Centers for Medicare and Medicaid Services' ("CMS") proposed rule establishing a limitation on hospital charges for services provided to IHS beneficiaries. As explained below, AzHHA is very concerned about the proposed rule and the adverse effect that it will have on its members. Accordingly, we request that IHS and CMS reconsider its proposed rule and revise the proposed rule as needed to address our concerns.

By way of background, AzHHA is a professional organization with a membership that includes over 100 hospitals in Arizona. Arizona has a large Native American population, accounting for over 4.2% of Arizona's population. As a result, a large number of Arizona hospitals currently provide services to IHS patients through a contract health service ("CHS") program, Tribe or Tribal Organization carrying out a CHS program, or program funded through a grant or contract by the IHS and operated by an urban Indian organization (collectively "I/T/U program"). Thus, the proposed rule is of significant concern to Arizona hospitals.

With respect to the proposed regulations, AzHHA has three primary concerns: (1) the proposed regulation does not clearly define what it means to "participate" in an I/T/U program; (2) the proposed reimbursement methodology is confusing, unworkable, and the reimbursement rate inadequate; and (3) the

2901 North Central Avenue, Suite 900 · Phoenix, Arizona 85012-2729 · (602) 445-4300 · Fax (602) 445-4299
www.azhha.org

proposed regulation provides no requirements for I/T/U programs designed to prevent I/T/U program abuses or to promote I/T/U-hospital relationships. We address each concern, and our recommendations, separately below.

I. The Proposed Rule Does Not Clearly Define What it Means to "Participate" in I/T/U Programs.

The proposed Medicare participation requirement, 42 C.F.R. § 489.29, states that a hospital that participates in the Medicare program must also "participate" in an I/T/U program. We request clarification on what it means to "participate" in an I/T/U program.

We believe that a hospital meets its requirement to participate in the I/T/U program as long as the hospital provides services to I/T/U program patients who present to the hospital for emergency care. We do not believe that hospitals should be required to provide non-emergency and elective services to I/T/U program patients at the capped payment rate, particularly when the I/T/U has the capability to provide the requested service within the IHS system. In addition, the regulation should clarify that hospitals are not obligated to accept patient transfers from I/T/U providers, except for patient transfers required under the Emergency Medical Treatment and Labor Act, which applies to all patients, irrespective of their insurance status.

As stated above, we do not believe that hospitals should be required to provide non-emergency and elective services to I/T/U program patients as a condition of Medicare participation. If hospitals must provide such services, then we request that the regulation state that hospitals are only required to do so subject to IHS regulations governing I/T/U eligibility, medical necessity, and purchase order requirements. Federal regulations state that payment will not be made for services provided by non-IHS hospitals unless the services are medically indicated, not reasonably accessible or available to be provided by IHS facilities, and, for non-emergency services, patients have been determined to be IHS eligible and have a valid purchase order. See 42 C.F.R. §§ 136.23; 136.24. If a patient presents to a non-IHS hospital and requests services that are not medically indicated or are reasonably available with the IHS system, or presents without a purchase order and proof of IHS or I/T/U eligibility, then the hospital should not be required to provide *non-emergency* services to the patient.

In addition, we request that the regulation clarify that while non-IHS hospitals are required to provide emergency care to I/T/U program patients, they are not required to enter into a "contract" or other provider agreement with I/T/U programs. Such a requirement would make little sense given the number of Medicare participating hospitals that rarely, if ever, encounter I/T/U program

patients. Further, if a contract is required, the terms of such an agreement have not been defined by regulation or published for public notice and comment as part of this proposed rulemaking. Medicare-participating hospitals should not be forced to enter into potentially unfair, restrictive, or burdensome contracts, with unspecified contract terms, with an individual I/T/U program in order to continue to participate in the Medicare program.

II. <u>The Payment Methodology Is Unworkable and Does Not Adequately Reimburse Hospitals That Provide I/T/U Program Services</u>.

Arizona hospitals have expressed significant concerns regarding the proposed reimbursement methodology and reimbursement rate. First, the payment rate is confusing and subject to different interpretations, in part due to the regulation's reference to 42 C.F.R. Part 413, subpart E. As a result, we are uncertain exactly how the "Medicare-like" payment mechanism will work. Accordingly, we request that before implementing the proposed regulation, CMS and the IHS provide more guidance with respect to this reimbursement methodology and give the public additional time to comment on the proposed reimbursement methodology.

If the "Medicare-like" payment will be determined based on a cost reimbursement mechanism under 42 C.F.R. Part 413, subpart E, even for hospitals that are currently paid under the PPS system, then the proposed methodology is unworkable. This methodology requires a determination of the hospital's "reasonable costs." The Medicare fiscal intermediary determines the hospital's reasonable costs on an annual basis, makes interim payments, and reconciles payments at the end of year, adjusting payments based on increases or decreases in hospital costs. This reimbursement mechanism, however, is not easily applied to hospitals that are primarily paid based on a prospective payment system.[1]

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[1] For example, while the proposed regulation references 42 C.F.R. Part 413, subpart E, it does not explain several aspects of the reimbursement mechanism: (1) who is responsible for making the reasonable cost determination, whether that be the Medicare intermediary, IHS, or I/T/U program; (2) the data that will be used to determine a hospital's reasonable costs; (3) the supporting documentation hospitals must provide, if any, to determine reasonable costs; (4) how this determination will be made in "real time" to reflect a hospital's actual reasonable costs (if Medicare cost reports are used, the most recent audited Medicare cost report will be at least two years old); (5) whether the determination will be based on average patient care costs or average patient case costs for the I/T/U population; (6) how hospital reasonable costs will be updated or adjusted to take into account increases or decreases in costs necessary to adequately reimburse hospitals for future I/T/U program services; and (7) the hospital appeal processes for adverse reasonable cost determinations. These issues need to be addressed. Indeed, depending on the framework, the methodology may be administratively burdensome, inconsistent, and difficult to implement. We question whether the resources necessary to implement this mechanism have

If the "Medicare-like" payment for hospitals that are not already reimbursed on a reasonable cost basis will be based on the Medicare DRG or other prospective payment rate, then the regulation needs to make this clear. Even under this methodology, the payment rate is insufficient to adequately reimburse hospitals for the services that they provide to I/T/U program patients. Several Arizona hospitals have reported that the average cost per case for IHS patients is greater than the average cost per case of Medicare patients. This is due, in part, to the relative health of this patient population[2] and the level of services that IHS patients tend to obtain outside the IHS system (*e.g.*, trauma). An interim rate less than or equal to existing prospective payment rates will not adequately reimburse hospitals for this patient population.

Second, the proposed payment methodology results in a decrease in hospital reimbursement, but without any guarantee of payment. An essential component of the Medicare reimbursement mechanism is the fact that hospitals are actually paid for the services that they provide and the existence of reconciliation processes, supplemental or add-on payments, or administrative cost reimbursement to ensure adequate reimbursement. The proposed "Medicare like" methodology has none of these components. In the past, when the IHS program has not been adequately funded or expenditures have not been well managed, non-IHS hospitals have been able to offset at least some of the risk of non-payment for services provided later in the year with higher payment rates. Under the proposed rule, however, hospitals must not only receive less reimbursement for their services, but they still may not be paid for their services, depending on when the patient received services, IHS funding, and IHS expenditures

We further believe that the requirement to "participate" in I/T/U programs, combined with the reduced reimbursement rate and lack of guaranteed payment for services rendered, constitutes an unfunded mandate on hospitals. While theoretically the lower reimbursement rates throughout the year would increase the likelihood of payment for all services rendered, as IHS funds extend further, there is no guarantee of this result. Indeed, the reduced payment for services may provide an *incentive* for I/T/U programs to refer more services out of the IHS network, since the IHS is not responsible for these costs. This is of particular

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taken into account in the regulatory impact statement, assuming that this is the reimbursement mechanism contemplated.

[2] In Arizona, for example, IHS patients have ranked worse than the statewide average in 48 out of 70 patient care indicators. They experience higher incidences of diabetes, alcoholism, infant mortality, motor vehicle accidents, and injuries, among other concerns. See Arizona Department of Health Services, "*Health Status Profile of American Indians in Arizona*" (2004).

concern if the proposed rule requires hospitals to provide non-emergency services to I/T/U patients without cost whenever IHS funds are exhausted. The requirement that Medicare-participating hospitals provide free non-emergency care to I/T/U program patients is extremely unfair to non-IHS hospitals, which have no control over IHS funds, expenditures, or purchase order determinations.

Finally, we believe that the payment mechanism will place some hospitals at risk. The proposed Regulatory Impact Statement demonstrates that in every scenario reviewed, the proposed regulation will have a negative impact on hospitals. The negative impact ranges from 1% to 8%, but in all cases, the impact is negative. While that impact may not seem significant, it is very significant to hospitals that have a large percentage of IHS patients and those hospitals, including small rural hospitals, that are in poor financial health. In Arizona, for example, over 60% of one non-IHS hospital's patients are IHS patients, with a large number of I/T/U program patients. This rural hospital has experienced financial difficulties and a 1% to 8% reduction in reimbursement could be devastating to this hospital.

Given the serious concerns that Arizona hospitals have with the proposed reimbursement methodology, AzHHA prefers a more straight-forward methodology. We recommend, for example, that CMS and IHS pay hospitals for I/T/U program patients based on a percentage in excess of the Medicare fee schedule amount. We recommend that this percentage take into account the high costs of providing services to the IHS population, given the relative health of this patient population, and the fact that non-IHS hospitals typically receive higher acuity patients or patients requesting high cost services, since these patients require services not routinely available in IHS facilities. In addition, we recommend a methodology that guarantees payment for services that hospitals provide to I/T/U program patients.

III. The Proposed Rule Places Additional Burden on Hospitals, With No Responsibility or Accountability for I/T/U Programs.

We appreciate the difficulty that some I/T/U programs have had negotiating and securing contracts with hospitals and the need to reduce the costs of IHS services. With this said, however, we do not believe that forcing hospitals to participate in I/T/U programs and capping hospital reimbursement rates is the best way to address this problem. While the small market share of I/T/U programs may have made it difficult for the programs to negotiate discounted rates, we believe that this is only one of the reasons for the historically high rates. In addition to the lack of guaranteed payment for services rendered, which is one disincentive to contracting with I/T/U programs, hospitals report a reluctance to participate in these programs due to serious I/T/U program abuses.

Despite I/T/U program regulations establishing eligibility, medical necessity, and purchase order requirements, hospitals report that some I/T/U programs have failed to comply with these requirements. Some I/T/U programs have improperly referred patients to non-IHS hospitals, either without purchase orders or eligibility determinations, reduced IHS services and facility hours as a convenience to IHS physicians and staff, shifting the burden to non-IHS facilities, created administrative obstacles to obtaining payment for services rendered, improperly denied claims, delayed payment, and refused payment for emergency care. These practices may be the result of the lack of adequate funding for IHS and I/T/U programs, but regardless of the cause, they need to be addressed.

The proposed rule, however, places an additional financial burden on hospitals, but fails to address these important concerns. In fairness to non-IHS hospitals, any law that requires hospitals to provide services to I/T/U program patients and limits reimbursement to hospitals for those services, with no guarantee of payment, should also hold I/T/U programs responsible for complying with regulatory requirements and dealing fairly with the hospitals that provide services to program patients. These provisions should include, for example:

- requirements that I/T/U programs timely process and promptly pay non-IHS hospital claims, similar to Medicare requirements;
- requirements for timely processing of billing errors, which is particularly important given the inability to do so at the end of the year;
- processes to better manage patient referrals and limit use of non-IHS facilities;
- more efficient and timely patient eligibility determinations;
- I/T/U program incentives to provide services directly or within the IHS system;
- penalties for program abuses and non-compliance; and
- recourse for hospitals that experience I/T/U program abuses.

There is no mechanism in the proposed regulation to ensure that I/T/U programs treat non-IHS hospitals fairly or to address I/T/U program abuses. Existing regulations have not been sufficient to address these concerns. These concepts are central to the Medicare reimbursement model. These concepts also are critical in a "Medicare like" I/T/U program reimbursement model. Without these concepts, hospital and I/T/U program relationships may deteriorate, which could have a negative impact on the success of these programs.

IV. Conclusion

For the reasons set forth above, we believe that IHS and CMS should reconsider its proposed rule limiting charges for services furnished by non-IHS hospitals that participate in the Medicare program. We believe that the regulation requires further clarification with respect to hospital participation in I/T/U programs, a more workable payment methodology with guaranteed payment for services rendered, and additional regulatory requirements for I/T/U programs to prevent program abuses.

We appreciate the opportunity to commenting on the proposed rule. If you have any questions or would like further information regarding our comments, please call me.

Sincerely,

John R. Rivers, FACHE
President and Chief Executive Officer

cc: The Honorable J.D. Hayworth
The Honorable Jon Kyl
The Honorable Rick Renzi