

MMPC Issue Matrix -- February 27, 2004

CMS #	Issues	Scope of Impact	CMS Response 1/17/04	Next Step
Active Issues				
2	Elimination of Medicare Part B late enrollment penalty [IHCIA NSC §428(b)(2)]	If only applied to 86 tribes back to 1999, number of AI/AN impacted probably only several thousand elders. If applied to all tribes (back to 1999) about 7,700 may be eligible. If applied to all tribes without retroactive date would impact about 21,000 AI/ANs seen at I/T/Us. Certainly not all would enroll in Part B, even with penalty removed.	"Equitable Relief" has been provided to AI/AN beneficiaries receiving services at IHS and Tribal facilities participating in Interagency Agreements between IHS and CMS during 1999 through 2003 regarding Outreach, Education and Enrollment Activity. Beneficiaries need to demonstrate to SSA (Jan – Mar 2004) that erroneous advice was provided resulting in their not enrolling in Medicare Part B when initially available. No permanent solution available	Respond to CMS announcement letter and request broader application and adequate implementation time.
3	All-inclusive rate for Medicare services provided in freestanding clinics .	Would provide rate for XXX (Elmer had this number) IHS and Tribal clinics, who now receive fee-for-service, FQHC or RHC.	Relates to Item # 1 (Provider-based clinic designation for Medicare (reimbursement of clinics at hospital outpatient reimbursement rates))	Confirm CMS does not have authority to grant.
4	Limitation on charges to CHS for inpatient care as a condition of Medicare participation [IHCIA NSC §415(a)]	Would positively impact all CHS budgets except those with better-than-Medicare negotiated hospital inpatient agreements.	Section 506 of the "Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173)" provides Indian health programs protection in that Medicare participating hospitals must accept no more than Medicare-like rates (set by the Secretary in regulations) from the Indian health programs as payment in full.	Determine timeline for rule development, process for tribal participation. IHS/Tribes develop implementation strategy.
5	Coverage of all Medicare services for which reimbursement is made to any provider (expansion from hospital, nursing home and limited Part B) [IHCIA NSC §416 am §1880(a)-(d)]	Myra, does this just impact I/T with hospitals or also those providing care out of federally owned facilities?	Section 630 of the "Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173)" amends 1880(e) by expanding coverage to Indian Health for all Medicare Part B items and services. Prior to this, BIPA 432 restricted payment to the Professional component only. This provision is time limited to 5 years in order to keep the Bill score within the \$400 billion budgeted amount. 5 year cost to the provision was estimated at \$60M, 10 year cost at \$170M.	Determine timeline for CMS implementation, process for tribal participation. IHS/Tribes develop implementation strategy.

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6	Reimbursement for cost of Medicare outreach, education and translation [IHCIA NSC §404(c)]	Will impact all I/T/Us	No Administrative solution	Framed in context with implementing new Medicare changes. Letter sent to Smith by TTAG 2/19/04. Clarify general funding versus “reimbursement”
9	Medicaid Administrative Match [IHCIA NSC §404(c)]	Number of tribal organizations impacted is unknown. Although all tribes are eligible, each state has discretion over how to, when to implement MAM. Currently operating for tribes in Washington, Alaska, Oregon, Myra where else???	Tribes are recognized as Public Entities for purposes of contributing federal matching funds on behalf of the state and can enter into MAM agreements with respective States. Tribal Organizations operating under Self-Determination authorities remains an unresolved issue as to whether they are considered a Tribe when operating under resolutions from Tribes. (reference 42 CFR 433.51)	CRIHB drafting letter. Clarify Indian organization issue versus state controlled MAM program and inclusion of tribes.
10	100% FMAP (Medicaid and SCHIP) (expansion to all I/T/U services including those obtained by referral) [IHCIA NSC §§421, 422 and 423]	Would benefit all tribes as well as state Medicaid programs. “by” and “through” issue.	No Administrative solution. Breakdown discussion to I – T – U s	CMS/Administration decision to appeal ND and SD court decision needs to be discussed. Confirm CMS does not have authority to grant.
11	Tribal FQHC 100% reasonable cost reimbursement [IHCIA NSC §§418 and 419]	Depending on other reimbursement options available, could benefit tribal clinics not eligible for IHS Medicare hospital outpatient all inclusive rate. May also benefit tribes if Medicaid FQHC rates would be higher than the IHS Medicaid encounter rate. Myra verify this: IHC clinics are not eligible for FQHC status.	BIPA 2000, Section 702 created a new Medicaid prospective payment system for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).	Does CMS Information answer issue?
15	Tribal self-insurance treated as payor of last resort vis-a-vis Medicaid	Unknown impact but probably limited. Only applies to AI/AN employed by tribe with self-insurance who is also enrolled in Medicare or Medicaid.	CMS OGC opinion – Tribal self-insurance does not apply when AI/AN beneficiary receives services in an IHS facility as IHS is prohibited from billing the tribal self-insurance plan. When patient receives services in non-IHS facility, Tribal self-insurance is primary payer, Medicare and Medicaid are secondary and IHS is residual. (3/28/02)	Confirm CMS position.

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16	State Indian Medicaid Advisory Committees [IHCIA NSC §431(b)]		Penny Thompson letter	Myra, what is the penny thompson letter?
17	State consultation with I/T/U [IHCIA NSC §420]		Penny Thompson letter	Ditto
18	Navajo Medicaid Agency demonstration project [IHCIA NSC §430]		No Administrative solution	Confirm CMS does not have authority to grant.
20 b	Prohibition on charging Indians for Medicaid premiums [IHCIA NSC §428(b)(1)]	Could affect AI/AN on Medicaid in states that charge premiums for Medicaid enrollment. Basis of Washington waiver issue.		NPAIHB and Washington tribes taking lead to contest current administrative policy change. MMPC to track.
21	100% FMAP for Medicaid services provided by (or through referral from) I/T/U [IHCIA NSC §423]		No Administrative solution	Myra, can we delete this and combine with CMS issue #10.
30	CMS consultation with I/T/U [IHCIA NSC §414(a)] (already underway)			
31	Negotiated rulemaking with CMS to implement IHCIA [IHCIA NSC §414(b)]		General discussion about implications to CMS' regulation process	Myra, can you help with this?

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32	Limitation on charges by outpatient health providers to CHS as condition of participation in M'r, M'd, SCHIP (UCR or lowest amount paid by any other payor) [IHCIA NSC §415(b)(1)]	Would positively impact all CHS budgets except those with better-than-Medicare negotiated hospital outpatient or community provider agreements.	Discuss consequences to retaining provider relationships.	MMPC proposal was not included in Medicare Act.
35	Safe harbor for purchasing, referral of patients and other exchanges among I/T/U health programs [IHCIA NSC §427]	<i>Myra, any idea how many I/T/U affected?</i>	Need Update from IHS/Tribal reps.	<i>Alaska taking lead on issue. Letter sent 2/04</i>
37	Limitation on charging Indians deductibles, co-pays, or co-insurance [IHCIA NSC §428(a)] – (Options for application: IHS only - I/T/U - I/T/U & providers who received a referral from I/T/U - all providers)	Assume Medicare, Medicaid and SCHIP. <i>Myra, are AI/AN SCHIP kids exempt from cost sharing at non-Indian facilities?</i> <i>Myra can we assume this means “collecting” at ITU? If not maybe we should break this into two issues – ITU and non-Indian provider. What do you think?</i> Because I/T/U cannot charge now, would impact AI/ANs out of pocket to non-Indian providers and/or CHS budgets paying external providers.	No Administrative resolution	Confirm CMS does not have authority to grant.
38 a	Prohibition of reducing reimbursement to I/T/U by amount of otherwise applicable from Medicaid deductibles, co-pays, and co-insurance [IHCIA NSC §428(a)]	Assume some positive impact for I/T/Us operating states that impose Medicaid deductibles or co-pays. Medicaid co-pays tend to be small.	No Administrative resolution	Confirm CMS does not have authority to grant.

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38 b	Prohibition of reducing reimbursement to I/T/U by amount of otherwise applicable SCHIP deductibles, co-pays, and co-insurance [IHCIA NSC §428(a)]	Myra do you know how this works anywhere?	No Administrative resolution	Confirm CMS does not have authority to grant.
38 c	Prohibition of reducing reimbursement to I/T/U by amount of otherwise applicable Medicare deductibles, co-pays, and co-insurance [IHCIA NSC §428(a)]	Would have growing positive impact on CHS budgets, especially where there is a high proportion of Medicare enrollees. Medicare Part B deductible \$100 and co-pay 20%. Myra, is this deducted somehow from the hospital outpatient all-inclusive rate? Would it only impact FFS, FQHC, RHC?	No Administrative resolution	Confirm CMS does not have authority to grant. This has not been an active issue but may arise in the future as new Medicare rules are developed.
41	Managed Care: various protections for I/T/U [IHCIA NSC §429]		Breakdown by I – T – U, need more information	This has not been an active issue but may arise in the future as new Medicare rules are developed for Part C and Part D.
44	Reimbursement for FSS drugs (and other FSS drug issues)		CMS to retract previous guidance to states and issue new guidance to reimburse for FSS Rx at cost.	Follow-up on CMS letter.
46	Require CHS & IHS to data match to produce complete report of IHS and CMS expenditures on Indian health care	Myra, can you say anything about these? Are they BOTH Jim's issue or just one of them?	Interagency Agreement activity between IHS and CMS	CRIHB taking lead
47	I/T/U data capacity development , including ability to produce cost reports		Interagency Agreement activity between IHS and CMS	CRIHB taking lead
Issues to Resolve with IHS				

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24	Direct payment conditions (rather than through IHS special fund) [IHCIA NSC §405]		IHS issue	
25	Reports required as condition of receipt of M'r, M'd, SCHIP [IHCIA NSC §403]		IHS issue	
26	I/T/U paying beneficiary monthly premiums [IHCIA NSC §404(a)(2)]		IHS issue	
27	Grants to assist with enrollment [IHCIA NSC §404]		IHS issue	
28	Applicability of M'r, M'd, SCHIP provisions to urban Indian organizations [IHCIA NSC §404(d) and others]		IHS issue	
29	Retention of reimbursement & no offset of IHS funding [IHCIA NSC §407]		IHS issue	
33	No recovery by other health providers against CHS for non-medically necessary procedures if already performed by I/T/U [IHCIA NSC §415(b)(2)]		IHS issue	
48	Reimbursement from other third parties [IHCIA NSC §406]		IHS issue	

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49	Authority to purchase insurance and managed care coverage for tribal and urban Indian program beneficiaries [IHCIA NSC §408]		IHS issue	
50	Study of medical facility sharing w/ VA and other federal agencies [IHCIA NSC §409(a)]		IHS issue	
51	VA required to reimburse I/T/U (expanded payor of last resort) [IHCIA NSC §409(b)]		IHS issue	
52	I/T/U as payor of last resort [IHCIA NSC §410]		IHS issue	
53	Right to recover from all federal health care programs [IHCIA NSC §411]		IHS issue	
Issues Resolved with CMS				

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1	Provider-based clinic designation for Medicare (reimbursement of clinics at hospital outpatient reimbursement rates) [IHCIA NSC §416 am §1880(e) [also addresses related EMTALA obligations]]		Changes in status of hospital or facility from IHS to Tribal operation, or vice versa, or realignment of a facility from one IHS or Tribal hospital to another IHS or Tribal hospital, will not cause a loss of grandfathered status for the facility if the resulting configuration is one which would have qualified for grandfathering under section 413.65(m) if it had been in effect on April 7, 2000. (8/11/03 letter to Trailblazer) EMTALA letters	
20 a	Prohibition on charging Indians for SCHIP premiums [IHCIA NSC §428(b)(1)] (May have been accomplished by CMS letter)	Small number of AI/AN enrolled in SCHIP.	SCHIP letter	SCHIP premium issue resolved for children.
42	Tribal TAG [IHCIA NSC §431(a) (already underway)]		Established	
Inactive Issues as of 2/25/04				
7	Reimbursement for CHAP services [IHCIA NSC §416 am §1880(d)]	Alaska only	Can these programs meet existing requirements?	
8	Reimbursement for visiting nurse services [IHCIA NSC §416 am §1880(f)]	Would this impact all tribes with community nursing programs?	Can these programs meet existing requirements?	Can MMPC/IHS identify specific barriers to reimbursement for this service?

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12	Application of value of I/T/U provided care to Medicaid spend down provisions of medically needy options [IHCIA NSC §428(c)]		Needs more study and information	
13	Tuba City Demonstration Project [IHCIA NSC §412]		On hold per direction from Navajo IHS	
14	Limitation on CMS authority to waive application of §1902(a)(13)(D) re: State Plans [IHCIA NSC §424] (May have been accomplished by CMS letter)			
19	Nationwide Medicaid uniform benefit package for Indians	Could have positive impact on many tribes, especially those in benefit-poor Medicaid states and in states cutting Medicaid benefits. However, the concept has never been clearly developed.	Need clarification	
22	Direct SCHIP funding of I/T/U for providing SCHIP-like services [IHCIA NSC §425]		Clarify. State has option to shift funding	
23	Federal mandate requiring states to include Indian adults under SCHIP		SCHIP inclusion of unborn children, Waivers to include parents and childless adults	
34	Authority of IHS and tribes to obtain waiver of provider sanctions [IHCIA NSC §426]		General discussion	

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36	Prohibition on charging Indians for Medicare premiums [IHCIA NSC §428(b)(1)]	Medicaid and SCHIP premiums addressed under CMS #20 Would affect AI/AN eligible for Medicare and enrolled in Part B or to enroll in new Part C (Medicare Advantage Plan) or Part D (drug benefit) (2006).	No Administrative resolution	Confirm CMS does not have authority to grant.
39	Limitation on estate recovery [IHCIA NSC §428(d)]		CMS State Manual Issuance # 75 clarifies what is excluded from estate recovery – basically that which is held in trust, derived from trust property, and/or culturally significant	
40	Limitation on medical child support recovery for care provided directly by or on referral from I/T/U [IHCIA NSC §428(e)]		No Administrative resolution	Confirm CMS does not have authority to grant.
43	QHIP (or alternate reimbursement methodologies) [IHCIA NSC §417; §416 am §1880(g)]		Study for alternative methods would need funding	
45	Limits on inpatient stays		Need more information	
54	Right to purchase federal insurance for tribal and urban Indian program employees [IHCIA NSC §413]		OPM issue	
55	Transfer budget from Interior appropriations to Labor/HHS		Congressional issue	
57	Home care and long term care		General discussion	

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58	Traditional medicine and healing		General discussion	
59	Across International border issues		General discussion	
60	Survey and certification of tribal facilities		General discussion	
61	Dual eligibility (Medicare & Medicaid) – cross-over payment issues		General discussion	