THE CENTERS FOR MEDICARE AND MEDICAID SERVICES
INTER-AGENCY AGREEMENT
Regarding Cost Reports

Between the Indian Health Service (IHS) and the Centers for Medicare and Medicaid Services (CMS).

I. Purpose

Under this agreement, IHS will develop an automated system in which their Agency personnel costs and other associated costs can be reallocated to health service cost centers such that cost hospital cost reports can more easily be produced.

II. Authority

The Economy Act of 1932, as amended (31 U.S. C. 1535), which authorizes transfer of funds from on agency to another under an interagency agreement.

III. Background

The IHS is an Agency in the Department of Health and Human Services (HHS). It is responsible for providing health care to more than 1.5 million eligible American Indians and Alaska Natives. The mission of IHS is to raise Indian health status to the highest possible level. IHS focuses its health programs on Indian tribes, which are diverse in terms of culture, history and size, as well as reservation size and geography. Health status also varies between tribes, but on the whole is considerably below that of the general population in the United States. With appropriations totaling approximately $1.6 billion in 2001, IHS administers its programs through 12 geographically defined IHS area offices, 47 IHS hospitals and 150 outpatient health centers, primarily located in rural and frontier settings.

The Indian Health Care Improvement Act, originally passed in 1974, amended Titles XVIII and XIX of the Social Security Act making it possible for CMS to pay the IHS, another Federal agency, for the Medicare and Medicaid services their providers provide to American Indian and Alaska Native Beneficiaries.

In order to justify the rates that are paid to the IHS, CMS requires Hospital cost reports. IHS currently files Method E cost reports, which is a truncated version of the Hospital Cost report (minus the various schedules). These Method E cost reports form the basis from which the Medicare and Medicaid all-inclusive rates are derived. As Medicare transitions away from cost reports and no longer relies on cost reports to establish IHS Medicare rates, Medicaid continues to rely on them for Medicaid all-inclusive rate payment purposes.

Although IHS has been increasing the number of cost reports produced each year, the process they follow in accomplishing this is highly time intensive. One of the major

obstacles to IHS producing cost reports in a timely and efficient manner is their accounting system and data subsystems. The major cost category for IHS is that of personnel costs. Although the Accounting for Pay system allows personnel costs to be split out among several cost centers, the system is not being used to its fullest extent. As a result, most personnel are charged to only one cost center despite perhaps working in multiple cost centers. Additionally, the Accounting for Pay system does have its' limitations for cost report purposes.

IHS would benefit from having the Accounting for Pay system revised and updated to better meet its needs. The system could then be distributed to all facilities for their use. Additionally, training on the system would be very important.

Once these are complete IHS will be able to move away from Method E cost reports to full-fledged hospital cost reports with all the various attached schedules. CMS feels strongly that IHS would benefit from having access to better management information provided by the full Hospital cost reports and that IHS would continue producing them to further satisfy their management information needs.

IV. Scope of Work and Responsibilities

The objective of this project is to ensure that IHS can more efficiently reallocate personnel costs using an automated system.

IHS will:

A. Prepare a draft Workplan detailing the work to be performed and how it will be performed, who will be involved, timeframes for accomplishing specific tasks, including delivery dates. Submit four copies of the draft Workplan to CMS along with materials that may help to clarify the work to be performed.
B. Prepare and submit monthly progress reports to work agreed upon in the approved work plan.
C. Upon completion of the new system/subsystem, IHS will provide training to its financial and accounting staff as to what the system entails and how to use it.
D. IHS will assure access to all facilities to all new systems/subsystems.
E. IHS will provide cost reports for all hospital facilities.
F. Prepare and submit a final report detailing the changes and accomplishments made in developing the new personnel cost allocation system/subsystem, the training provided and what degree of access is available to financial/accounting staff.

CMS will:

A. Provide to IHS funding in the amount of $400,000 for the purpose of carrying out IA activities.
B. Meet with IHS to discuss and agree upon Workplan.
C. Participate in monthly project conference calls.

D. Review and provide comments on monthly progress reports within one week of receipt.
E. Make available technical staff to advise on an as needed basis throughout the course of the IA.

V. Schedule of Activities

A. IHS to submit Workplan no later than June 14, 2002
B. Meeting with IHS and CMS to discuss Workplan by no later than June 28, 2002
C. Submit and receive monthly progress reports
D. Hold monthly Project Officer conference calls beginning July 30, 2002 to discuss the progress of the project. Others will be invited to participate as appropriate, such as CMM cost report staff and IHS finance/accounting staff.
E. Final report due one month following the completion of the development and training phases of the project.

VI. Duration of Agreement

This agreement provides for FY 2002 funding. It is effective upon signature of both parties for a period of 12 months. This agreement may be continued upon the approval of both agencies.

VII. Project Officers

IHS:
Dan Madrano
Indian Health Service
Reyes Building
801 Thomas Avenue
Rockville, MD 20852
301/443-1270

CMS:
Dorothy A. Dupree, MBA
Senior Policy Advisor, AI/AN Programs
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mailstop: S3-16-16
Baltimore, MD 21244
410/786-1942
ddupree@cms.hhs.gov

VIII. Funds

Transfer of Funds

FROM:	**CMS**	**TO:**	**IHS**
Agency Symbol:	75050080	Agency Symbol:	75030030
Appropriation:	7520511	Appropriation:	7520390
CAN:	15997235	CAN:	2J942090
Object Class:	2539	Object Class:	25.39
Allotment:	50	Allotment:	2-39000
Allowance:	752	Allowance:	194
EIN:	52-0883104	EIN:	52-0821668
Control Number:	**IA-**		
FMIB Number:	9350		
Amount:	$400,000	Amount:	$400,000
Billing Contact:		Billing Contact:	
Jean Katzen		Laurie Kitto	
(410) 786-5423		(301) 443-2529	
(410) 786-7259 (Fax)		Indian Health Service	
		Reyes Building	
		801 Thompson Avenue	
		Rockville, MD 20852	

The IHS will bill CMS through the on-line payment and collection system (OPAC) after receipt of the signed IA by all parties. CMS will transfer FY 2002 funds not to exceed $400,000 to the IHS. Prior to the OPAC submission to CMS, the IHS shall submit payment documentation to justify the OPAC billing that will be submitted to CMS. Send this documentation to:

Jean Katzen
P.O. Box 7520
Baltimore, MD 21207-0520

Agencies submitting OPAC bills to CMS without funds documentation will be charged back if documentation is not received within five working days of OPAC submission. Please include the following CMS control number on the OPAC submission: **IA** -

MAILING ADDRESS:
Centers for Medicare and Medicaid Services
Office of Financial Management
Division of Accounting
POB 7520
Baltimore, MD 21207-0520

IX. Duplication

Full implementation of this agreement will not duplicate existing agreements.

X. Privacy Act/Systems Security

This agreement is not subject to the requirements of the Privacy Act, as it will not involve the release of CMS data.

CMS:

_____ _____
Dennis G. Smith DATE
Director
Center for Medicaid and State Operations

IHS:

_____ _____
Duane Jeanotte DATE
Acting Director of Headquarters Operations
Indian Health Service