# BETTER BENEFITS – MORE CHOICES

*Good News about the Medicare Prescription Drug, Improvement and Modernization Act of 2003!*

## Several MMA Provisions Directly Impact Delivery of Health Services to American Indians and Alaska Natives

## Provider Provisions

### Section 506 – Medicare-like rates

*Background*:

- Indian health programs provide mostly primary and preventive health care directly, with their own facilities and staff. They often buy more specialized services for their beneficiaries from other providers. The Indian Health Service (IHS) and Indian Tribes use Contract Health Services funds to buy this care. Urban Indian organizations use some of their IHS contract or grant money for the purchase of care.

- Much of this specialized care is purchased from hospitals that often charge the Indian health programs very high rates. The Indian health programs try to negotiate reasonable rates, but frequently lack sufficient market share to be successful.

*New Provisions in MMA*

- Indian health programs will now benefit from Medicare's bargaining power when buying care for their non-Medicare patients. **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.** This change will be effective for hospitals with Medicare participation agreements in effect or entered into on or after a date specified by the Secretary, no later than December 8, 2004.

### Section 630 – Billing for all Part B Services

*Background*

- Facilities operated by IHS are subject to the general prohibition against Federal providers billing Medicare.

- Since 1976, section 1880 of the Social Security Act has given IHS facilities exceptions to this prohibition for payment for hospital and SNF services.

- Since July 1, 2001, under provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), the exception also has covered Part B services paid under certain fee schedules. This has produced some strange results – Medicare can pay IHS for sigmoidoscopies, colonoscopies, and the doctor's visit (because they are paid under such fee schedules) but not for the less costly fecal occult blood test screenings (which are paid differently).

*New Provision in MMA*

- The new law expands the exception **to allow IHS-operated facilities to be paid for all other covered Part B items and services for 5 years**, beginning January 1, 2005.

## Section 1011 – Federal reimbursement of emergency health services furnished to undocumented aliens

*Background*

- Section 1867 of the Social Security Act (known as EMTALA) requires a hospital that has an emergency department to provide appropriate medical screening to individuals who request examination or treatment to determine whether or not an emergency medical condition exists and, if it does, to stabilize the condition and/or provide an appropriate transfer. These requirements apply, regardless of the individual's ability to pay for treatment, their citizenship, or the legality of their presence in the U.S.

- Undocumented aliens frequently are unable to pay for EMTALA-required care they receive from hospitals and the doctors and ambulance services associated with them. This is a growing burden, particularly in areas with significant numbers of undocumented aliens.

- IHS and Tribal hospitals with emergency departments are bound by EMTALA requirements on the same basis as other hospitals. When they must provide uncompensated care to undocumented aliens, it uses up a portion of the limited funds available for their primary mission of providing health care

services to American Indians and Alaska Natives (AIANs) who are citizens or legal residents of the U.S.

*New Provisions in MMA*

- **The new law provides $250 million per year for FY 2005-2008 for the Secretary to directly pay hospitals, doctors, and ambulance providers for their otherwise uncompensated costs of providing emergency health care required under EMTALA and related hospital inpatient, outpatient, and ambulance services to certain aliens.** The definition of providers eligible to request this funding specifically includes IHS facilities operated by the IHS or by an Indian Tribe or Tribal organization.

- Payments will be made quarterly and may be made based on advance estimates with retrospective adjustments. The Secretary must establish a process, no later than September 1, 2004, for eligible providers to request payments.

## Medicare Endorsed Drug Discount Card

*Background*

- A number of AIANs use health programs operated by the IHS, Tribes and Tribal organizations, and urban Indian organizations. Such programs may be the closest or even the only health care providers in many remote communities and receive limited domestic discretionary funding. Some of these programs operate pharmacies; those operated by the IHS and Tribes can purchase drugs through the Federal Supply Schedule at discounted prices.

*New Provisions in MMA*

- AIAN Medicare beneficiaries will have the **option to enroll in a drug discount card program and to receive Transitional Assistance – up to $600 per year for help affording prescription drugs until the full drug benefit begins in 2006** – on the same basis as other Medicare beneficiaries.

- **Individuals who are enrolled under Medicaid and are entitled to have Medicaid pay for outpatient prescription drugs or who have coverage of or assistance in paying for prescriptions by a group health plan, health insurance, or military or Federal employees' health plans are not eligible for the discount card program.** They can continue to receive prescription drug benefits through these other plans and programs. However, use of Indian health programs and receiving prescription drugs from them does not prevent an

otherwise eligible Indian Medicare beneficiary from using the discount card or transitional assistance.

- The **transitional assistance can be used to pay for drugs supplied by IHS, Tribal, and urban Indian organization pharmacies and will help those programs stretch their funding farther.** AIAN beneficiaries who purchase drugs from other sources can use the card (and the transitional assistance) at any other pharmacies in their card network.

- The Secretary must establish procedures, and may waive requirements of the drug discount card section of the law, to ensure that, for purposes of the transitional assistance program, pharmacies operated by Indian health programs have the opportunity to participate in the pharmacy networks of at least two endorsed programs in each of the 50 States and District of Columbia where such a pharmacy operates. The interim final regulation on the drug card establishes a process, including certain waivers to encourage card sponsors to apply for "special endorsement" to meet this requirement.

- Other provisions may help overcome the cost-sharing barrier noted above. Pharmacies participating in discount card networks may waive or reduce beneficiary coinsurance. Such reductions by pharmacies (including pharmacies of Indian health programs) are given a "safe harbor" from usual prohibitions in the Social Security Act against offering or paying a Medicare beneficiary to use a covered benefit, if specified conditions are met.

## Medicare Part D Prescription Drug Benefit

*Background*

- As noted above for the discount card, many AIANs use Indian health programs and their pharmacies and cost sharing requirements present a significant barrier to using benefits for which they are eligible or entitled.

*New Provisions in MMA*

- AIAN Medicare beneficiaries will be eligible for Part D on the same basis as other Medicare beneficiaries.

- Certain provisions will make it **easier for AIAN Medicare beneficiaries to use pharmacies.** A Prescription Drug Plan (PDP) must permit any pharmacy willing to meet the terms and conditions of that plan to participate in its network. Also, the Secretary must establish rules for PDP sponsors regarding convenient access by enrollees of the PDP plan to pharmacies in the plan network that are no less favorable to the enrollees than those established for

TRICARE as of March 13, 2003. Such rules may include standards with respect to access for pharmacies operated by IHS, Tribes, Tribal organizations, and urban Indian organizations.

- **Similar provisions to the discount card may help overcome the cost-sharing barrier.** PDP and Medicare Advantage-PD plans may reduce otherwise applicable cost sharing down to zero, but only for preferred or generic drugs. As with the drug discount card, such reductions by pharmacies (including pharmacies of IHS, Indian Tribes and Tribal organizations, and urban Indian organizations) are given a "safe harbor" from prohibitions against offering or paying a Medicare beneficiary to use a covered benefit, if specified conditions are met.