

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**IHS CONTRACT HEALTH
SERVICES PROGRAM:
OVERPAYMENTS AND POTENTIAL
SAVINGS**



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OBJECTIVES

1. To determine the extent to which the Indian Health Service (IHS) and tribes paid for Contract Health Services (CHS) program hospital claims above the required Medicare rate.
2. To assess the potential savings if CHS program nonhospital claims were paid at the Medicare rate.

BACKGROUND

In fiscal year 2008, IHS was given a budget of \$3.35 billion to provide health care to approximately 1.9 million American Indians and Alaska Natives belonging to federally recognized tribes. IHS can provide health care directly or tribes can operate their own health care programs. IHS and tribes provide direct health care to American Indians and Alaska Natives mainly at small health clinics offering routine health care.

When an IHS or tribal health-care facility is not available or does not provide required emergency or specialty care, IHS and tribes rely on the CHS program. IHS manages the CHS program through 84 area offices and local service units. Tribes manage the CHS program through 175 tribally operated service units.

Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and IHS's implementing regulations, all Medicare-participating hospitals must accept reimbursement no greater than the Medicare rate as payment in full for patients eligible for CHS. Nonhospital providers, such as physicians, are not covered by this MMA provision.

We analyzed 716 paid CHS claims for services delivered between January and March 2008. For each claim, we determined the Medicare rate. We then calculated the difference between the Medicare rate and the CHS payment. We projected all statistics to IHS and the 63 percent of tribes from which we received claims.

FINDINGS

IHS and tribes paid above the Medicare rate for 22 percent of hospital claims between January and March 2008, resulting in \$1 million in overpayments. While 22 percent of hospital claims

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were paid above the Medicare rate, the resulting overpayments only accounted for 3 percent of the total \$33 million that IHS and tribes spent on hospital claims between January and March 2008. Most overpayments were for hospital outpatient claims. Tribes accounted for most dollars overpaid.

If IHS and tribal payments for nonhospital claims were capped at the Medicare rate, they could have saved as much as \$13 million between January and March 2008. IHS and tribes paid above the Medicare rate for 71 percent of nonhospital claims. Most of these claims paid above the Medicare rate were for physician services.

RECOMMENDATIONS

IHS and tribes should take appropriate action regarding overpaid CHS hospital claims. We have forwarded all IHS hospital claims that we determined were overpaid to IHS, and all tribal hospital claims that we determined were overpaid to tribes.

IHS should direct its fiscal intermediary to ensure that all future CHS hospital claims are paid at or below the Medicare rate. We found that the IHS fiscal intermediary paid \$231,000 over the Medicare rate for hospital claims.

IHS should provide technical assistance to tribes to ensure proper payments of hospital claims. As a first step, IHS and tribes could work together to determine why hospital claims were paid over the Medicare rate. IHS could then develop guidance to prevent future overpayments.

IHS should seek legislative authority to cap payments for CHS nonhospital services. The passage of the MMA provision helped ensure lower rates for hospital services. A separate provision may be necessary to ensure lower rates for nonhospital services.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

IHS concurred with all four of our recommendations. We did not make any changes based on IHS comments.



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OBJECTIVES

1. To determine the extent to which the Indian Health Service (IHS) and tribes paid for Contract Health Services (CHS) program hospital claims above the required Medicare rate.
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BACKGROUND

Indian Health Service

IHS provides health care to approximately 1.9 million American Indians and Alaska Natives belonging to federally recognized tribes. IHS can provide health care directly or may fund tribes to independently deliver health care. The Indian Self-Determination and Education Assistance Act (ISDEAA) allows individual tribes, or consortia of tribes, the option to operate health care programs in lieu of IHS through self-determination contracts or self-governing compacts with IHS.¹

In fiscal year (FY) 2008, IHS's budget was \$3.35 billion.² With this, IHS and tribes provided health care directly at more than 700 facilities across the country, mainly on reservations or in rural communities.³ Most of these facilities were small health clinics providing routine health care. In addition, IHS and tribes directly funded 46 hospitals, of which 20 had operating rooms.⁴

Contract Health Services

When an IHS or tribal facility is not available or does not provide required emergency or specialty care, IHS and tribes rely on the CHS program. Over 17 percent of the IHS budget went to fund the CHS program in FY 2008.

¹ Titles I and V of the Indian Self-Determination and Education Assistance Act, P.L. No. 93-638 (as amended).

² IHS, "FY 2009 Budget Justification." Available online at http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/bf_cong_justifications.asp. Accessed on March 24, 2009.

³ IHS, "Fact Sheets: Facilities Construction." Available online at <http://info.ihs.gov/FcItCnstr.asp>. Accessed on March 24, 2009.

⁴ "Access to Contract Health Services in Indian Country: Hearing Before the U.S. Senate Committee on Indian Affairs," 107th Cong. 4 (2008). Statement of Robert McSwain, Director of IHS.

I N T R O D U C T I O N

The CHS program contracts with private providers, such as hospitals and physicians, to deliver health care. CHS program staff try to negotiate the lowest price possible to deliver services to the American Indian and Alaska Native population in their area. Historically, IHS and tribes have had difficulty negotiating low rates due to the relatively small number of eligible individuals and because there are few private providers in rural areas.⁵

The CHS program is administered and managed through 259 IHS- and tribally operated service units. Service units contain one or more hospital, health clinic, or other health care facility. IHS manages the CHS program through 84 area offices and local service units. Tribes manage the CHS program through 175 tribally operated service units. Compacting tribes can supplement and reallocate CHS funds without IHS approval.⁶

CHS medical priorities. Due to limited funding, the CHS program can typically only fund the highest medical priority care, such as emergency care.⁷ The CHS program often defers or denies lower-priority services, including specialty care. Among IHS CHS programs, an estimated 200,000 services were deferred or denied in 2008. This figure only includes IHS CHS programs and thus would likely be significantly greater if tribes were included.

CHS payments. The CHS program is the payer of last resort.⁸ If an American Indian or Alaska Native receiving CHS has other insurance coverage such as Medicare or Medicaid, that insurance pays first and CHS funds pay for any remaining costs.⁹ If a patient does not have other insurance, the CHS program pays for claims in full or at a rate negotiated with a provider as long as there are CHS program funds to do so.

Generally, IHS and tribes use different claims processing and reimbursement systems to pay private providers. IHS contracts with BlueCross BlueShield of New Mexico as a centralized fiscal

⁵ IHS, "Contract Health Services." Available online at <http://info.ihs.gov/CHS.asp>. Accessed on March 24, 2009.

⁶ ISDEAA § 506(e), 25 U.S.C. § 458aaa-5(e).

⁷ IHS, "Fact Sheets." Available online at <http://info.ihs.gov/CHS.asp>. Accessed on April 14, 2009. 42 CFR § 136.23(e).

⁸ 42 CFR § 136.61.

⁹ 42 CFR § 136.30(g).

intermediary to process CHS claims.¹⁰ Eight tribes also use this fiscal intermediary. The remaining tribes use other systems to pay providers.

CHS and Hospital Services

Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and its implementing regulations, all Medicare-participating hospitals must accept reimbursement no greater than the Medicare rate as payment in full for patients eligible for CHS.¹¹ This change took effect on July 5, 2007.

The MMA provision applies to both hospital inpatient overnight stays and same-day hospital outpatient visits. Hospital facilities include acute care hospitals, psychiatric hospitals, critical-access hospitals, and long-term care hospitals.¹² We consider all claims for services provided in these facilities to be “hospital claims.”

CHS and Nonhospital Services

The MMA provision does not apply to nonhospital facilities. For instance, independent laboratories, ambulatory surgical centers, and independent ambulance providers are not covered and therefore are free to bill and receive payment above the Medicare rate for patients eligible for CHS. Additionally, physician services, including those provided in a hospital, are not covered by the MMA provision. We consider all claims for physician services and services provided in nonhospital facilities to be “nonhospital claims.”

Related Reports

A 1999 Office of Inspector General (OIG) study found that in 1995, the CHS program paid almost \$5 million more than the Medicare rate to hospitals. That study focused on hospital inpatient stays funded only by IHS. It did not review claims from tribes, or any claims for hospital outpatient visits.¹³ Subsequent to that study, IHS required Medicare-participating hospitals to accept reimbursement

¹⁰ IHS, “Contract Health Services Data Quality Workgroup, CHS 101.” Available online at <http://www.ihs.gov/NonMedicalPrograms/dqwg/dqwg-section1-home.asp>. Accessed on March 24, 2009.

¹¹ Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 506, P.L. No. 108-173; 42 CFR § 136.30.

¹² 42 CFR § 489(b).

¹³ OIG, “Review of the Indian Health Service’s Contract Health Service Program,” A-15-97-50001, January 1999.

equal to or lower than the Medicare rate for patients eligible for CHS, pursuant to the authority granted in the MMA provision.

METHODOLOGY

Below we provide a basic description of our methodological approach. See Appendix A for a more detailed description of our methodology.

Scope

We analyzed paid CHS claims for services provided between January and March 2008. We excluded claims for services that did not have a corresponding Medicare rate and claims in which the patient had another form of insurance, such as Medicare, Medicaid, or private insurance.

While we calculated the extent to which claims were paid at a rate greater than the Medicare rate for hospital and nonhospital services, we did not make a causal determination as to why some claims were overpaid.

Sample and Data Collection

We requested paid CHS claims from the IHS fiscal intermediary and the 167 tribes that do not use the fiscal intermediary for services delivered between January and March 2008. We requested that programs submit only CHS claims that were not covered by another type of insurance. We also requested that programs separate hospital and nonhospital claims.

We received claims from the fiscal intermediary for all 84 IHS area offices and local service units administering the CHS program and the 8 tribes processing claims through the fiscal intermediary. We received information directly from 102 of the 167 tribes that do not use the fiscal intermediary. Despite repeated requests, we did not receive any information from 65 tribes.

Next, we reviewed the claims submitted by IHS and tribes and excluded any claims that were outside of our scope. After this, we had 80,043 claims.

From these 80,043 claims, we pulled a stratified random sample of 800 claims. The four strata were: IHS hospital, tribal hospital, IHS nonhospital, and tribal nonhospital. Each stratum contained 200 claims. To improve the precision of our estimates, we further stratified the 80,043 claims by the amount paid (small, medium, and large).

We also collected and reviewed all relevant laws, regulations, and guidance regarding CHS programs and Medicare pricing for services.

Data Analysis

In total, we analyzed 716 of the 800 sampled claims. We excluded the remaining 84 claims primarily because, upon further review, they fell outside of our scope. Unless otherwise noted, we project all statistics to IHS and the 63 percent of tribes from which we received claims. See Appendix B for a list of 95-percent confidence intervals for all statistical projections.

Determining the Medicare rate. To determine the Medicare rate, we used the appropriate pricing software and fee schedules for 2008. For inpatient hospital claims, the Medicare rate is based on the inpatient prospective payment system (IPPS).¹⁴ We used the Centers for Medicare & Medicaid Services' (CMS) publicly available IPPS pricing software system to determine the Medicare rate for inpatient CHS claims.

For outpatient hospital claims, the Medicare rate is based on an outpatient prospective payment system.¹⁵ Most services are classified into clinically similar groups called Ambulatory Payment Classifications (APC). For hospital outpatient claims, we used pricing software developed by MediRegs¹⁶ to determine the APC price. However, some services do not use an APC code. In these cases, we used various fee schedules, including the 2008 clinical laboratory fee schedule.

For claims from cost-based facilities, such as critical-access hospitals, the Medicare rate is based on each hospital's per diem and cost-to-charge ratio. We relied on the per diem and cost-to-charge ratio from the most recently settled cost report to determine the Medicare rate for cost-based facilities.

For nonhospital claims, the Medicare rate is based on a variety of methods, including Relative Value Units (RVU) for physician services and fee schedules for other nonhospital services. We used the

¹⁴ 42 CFR § 136.30(c).

¹⁵ 42 CFR § 136.30(c).

¹⁶ MediRegs is a private company that developed health care compliance software in collaboration with the National Institutes of Health's Health Services Research Library. Mediregs, "Coding and Reimbursement Resources." Available online at http://hsrl.mediregs.com/cgi-bin/trial/index_gen?page=q. Accessed on August 22, 2008.

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MediRegs RVU pricing software for physician services and various Medicare fee schedules, including the 2008 ambulance fee schedule, for other nonhospital services.

Determining the difference between CHS payments and the Medicare rate. After we calculated the Medicare rate for sampled hospital claims, we calculated the difference between the Medicare rate and CHS payment. We calculated the percentage of claims paid above the Medicare rate. We determined whether there was a difference in the percentage of claims paid above the Medicare rate between IHS and tribes. We tested whether the difference was statistically significant at the 95-percent confidence level. If the paid amount was above the Medicare rate, we determined by how much. We also calculated the percentage of claims paid at or below the Medicare rate.

We performed a similar analysis of nonhospital claims to determine any potential savings.

We also estimated the number of additional claims IHS and tribes could have paid with hospital overpayments and the potential nonhospital savings. To do this, we calculated an average Medicare rate for hospital claims in our sample. We then divided total overpayments for hospital claims by our calculated, average hospital Medicare rate. We performed a similar analysis for potential savings from nonhospital claims.

Limitations

When determining the Medicare rate for sampled claims, we priced the services as they were coded. We did not attempt to check the accuracy of the coding. IHS and tribes may have applied edits to incorrectly coded claims. We expect that most of these edits would reduce CHS payments because IHS and tribes would likely apply edits to ensure that providers did not bill at higher rates than appropriate. Thus, we expect that in most cases, edits reduce payments to providers. Therefore, if IHS and tribes performed edits on claims in our sample, we expect that it would only affect the distribution between claims paid at the Medicare rate and claims below the Medicare rate. We do not expect that it affected our estimates of claims paid above the Medicare rate.

We were unable to determine the exact wage index to apply to hospital claims. The wage index adjusts for health-care costs across geographic regions and types of hospitals. A hospital's wage index changes slightly within a year, changing its Medicare rate. We

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controlled for this by using multiple versions of the inpatient and outpatient pricing software. As a result, we expect any differences attributable to changing wage indexes to be minimal.

When determining the Medicare rate, we did not consider whether services were provided in a Health Professional Shortage Area¹⁷ or Physician Scarcity Area.¹⁸ Medicare pays providers in these areas quarterly bonuses based on their volume of claims. Thus, the total Medicare payments for claims in these areas may be slightly higher than the Medicare rate we calculated.

Standards

This study was conducted in accordance with the “Quality Standards for Inspections” approved by the Council of the Inspectors General on Integrity and Efficiency.

¹⁷ A Health Professional Shortage Area is a federally designated area reflecting a shortage of primary medical care, dental, or mental health providers. Providers in these areas are paid a 10-percent quarterly bonus on all claims. See SSA § 1833(m).

¹⁸ A Physician Scarcity Area is an area with a shortage of primary care physicians or specialty care physicians. Physicians in these areas are paid a 5-percent quarterly bonus on all claims. See SSA § 1833(u).

► FINDINGS

IHS and tribes paid above the Medicare rate for 22 percent of hospital claims between January and March 2008, resulting in \$1 million in overpayments

Despite the MMA provision, IHS and tribes overpaid for 22 percent of hospital claims between January and March

2008. As a result, IHS and tribes overpaid \$1 million in this period. IHS and tribes could have used this money to pay for approximately 570 additional hospital claims, based on the average Medicare rate of \$1,900 per hospital claim. These overpayments could have paid for hospital services that might otherwise have been deferred or denied.

On the other hand, this \$1 million only accounts for 3 percent of the total \$33 million that IHS and tribes spent on hospital services between January and March 2008. In fact, most claims were paid in accordance with the MMA provision just 6 months after its implementing regulation went into effect.

IHS and tribes paid at or below the Medicare rate for 78 percent of hospital claims. Specifically, IHS and tribes paid at the Medicare rate for 59 percent of hospital claims and paid below the Medicare rate for 19 percent of hospital claims.

When hospital claims were overpaid, most overpayments were modest. The median amount overpaid was \$24. The average overpayment was \$280. Yet, there were a few significant overpayments. In our sample, IHS and tribes overpaid between \$10,000 and \$34,000 on four hospital claims. The largest overpayment was for a claim covering primarily laboratory tests and drugs.

Most overpaid hospital claims were for outpatient services

Ninety percent of the overpaid hospital claims were for hospital outpatient claims, totaling \$752,000. In addition, hospital outpatient claims were overpaid 24 percent of the time. In contrast, inpatient claims were overpaid only 12 percent of the time.

Some overpayments for outpatient services may be attributable to varying pricing software or to confusion about the payment methodology. Because there is no publicly available outpatient claims pricing software, IHS and tribes use a variety of pricing software. IHS generally recommends purchasing pricing software from a commercial vendor or contracting with a fiscal intermediary. Varieties of pricing software differ in their comprehensiveness. For example, one type of software only calculates the Medicare rate for services with an APC code, requiring the user to access additional fee schedules for services

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without an APC code. On the other hand, another type of software calculates the Medicare rate for all services, including those without an APC code.

Only 10 percent of claims paid over the Medicare rate were for inpatient hospital services. For pricing inpatient claims, IHS recommends the use of CMS's IPPS pricing software. IHS has worked with CMS to provide a step-by-step guide to pricing inpatient claims using this software, including guidance on how often to download the most recent version of the CMS software.

Tribes accounted for most dollars overpaid

Tribal CHS hospital claims accounted for 79 percent of the \$1 million overpaid for hospital claims.¹⁹ Tribes paid \$860,000 above the Medicare rate while IHS paid \$231,000 above the Medicare rate for hospital claims.

There is no statistically significant difference between IHS and tribes in the percentage of claims paid above the Medicare rate; however, tribes paid higher amounts above the Medicare rate for hospital claims. On average, tribes overpaid \$534 per overpaid hospital claim. IHS overpaid \$101 per overpaid hospital claim.

If IHS and tribal payments for nonhospital claims were capped at the Medicare rate, IHS and tribes could have saved as much as \$13 million between January and March 2008

If payments for nonhospital claims were capped at the Medicare rate, potential savings to IHS and tribes would have ranged from \$10 million to \$13 million.

IHS and tribes paid \$13 million above the Medicare rate for nonhospital claims, representing 71 percent of claims. IHS and tribes are not required to pay for nonhospital services at or below the Medicare rate. Instead, IHS and tribes pay nonhospital claims in full or at rates negotiated with the provider. There is no statistically significant difference in the percentage of claims paid above the Medicare rate between IHS and tribes.

If all nonhospital claims were paid at the Medicare rate, including those claims that were paid below the Medicare rate, IHS and tribes would still have realized a net savings of \$10 million between

¹⁹ The total amount overpaid for hospital claims was \$1.1 million. This explains why 79 percent equals \$860,000.

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January and March 2008. While the majority of nonhospital claims were paid above the Medicare rate, 29 percent were paid at or below the Medicare rate. Of these, 14 percent were paid at the Medicare rate. Additionally, for 15 percent of claims, providers accepted CHS payments below the Medicare rate. This 15 percent of claims total \$3 million below the Medicare rate.

Imposing a cap may result in claims that are currently being paid below the Medicare rate rising to the Medicare rate. However, IHS and tribes proved that it is possible to successfully negotiate rates lower than the Medicare rate when a payment cap is in effect. For instance, 19 percent of hospital claims were paid below the Medicare rate after the MMA provision went into effect. Thus, it is possible that IHS and tribes could have saved \$13 million if nonhospital services were capped at Medicare rates.

The \$13 million paid above the Medicare rate for nonhospital claims represents almost half of the total \$28 million spent on nonhospital claims during this period. IHS and tribes could have used the \$13 million in savings to pay for approximately 41,000 additional nonhospital claims between January and March 2008, based on the average Medicare rate of \$321 per nonhospital claim. Among IHS CHS programs, an estimated 200,000 services were deferred or denied in 2008.²⁰ This figure only includes IHS CHS programs and thus would likely be significantly greater if tribes were included.

The median amount paid above the Medicare rate for nonhospital claims was \$98 and the average was \$327. There were some particularly large payments over the Medicare rate. In our sample, IHS and tribes paid between \$10,000 and \$49,000 above the Medicare rate on 14 nonhospital claims. The largest payment above the Medicare rate was for a claim covering physician services from a cardiothoracic surgical group.

²⁰ As we only know the number of services deferred or denied, we cannot determine the number of claims deferred or denied. One claim can include many services.

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Ninety-one percent of nonhospital claims paid above the Medicare rate were for physician services. Overall, physician services made up 88 percent of all nonhospital claims. The remaining 9 percent of nonhospital claims paid above the Medicare rate were for ambulance services, durable medical equipment, and services provided in ambulatory surgical centers.

► R E C O M M E N D A T I O N S

Within 6 months after the MMA requirement went into effect, IHS and tribes paid above the Medicare rate for 22 percent of hospital claims. As a result, IHS and tribes overpaid \$1 million for hospital claims between January and March 2008. The majority of overpaid claims were for hospital outpatient services.

If IHS and tribal payments for nonhospital claims were capped at the Medicare rate, IHS and tribes could have saved as much as \$13 million between January and March 2008. These savings could have allowed IHS and tribes to pay for a significant number of services to American Indians and Alaska Natives who might otherwise have gone without needed health care.

Our findings led us to the following recommendations:

IHS and Tribes Should Take Appropriate Action Regarding Overpaid CHS Hospital Claims

IHS and tribes paid above the Medicare rate for 22 percent of hospitals claims, in violation of the MMA provision. We have forwarded all IHS hospital claims that we determined were overpaid to IHS for followup. We have forwarded all tribal hospital claims that we determined were overpaid to tribes. IHS should take action to collect any overpayments paid through the IHS fiscal intermediary. Tribes should do likewise.

IHS Should Direct Its Fiscal Intermediary To Ensure That All Future CHS Hospital Claims Are Paid at or Below the Medicare Rate

We found that the IHS fiscal intermediary paid \$231,000 over the Medicare rate for hospital claims. IHS should direct the fiscal intermediary to ensure that no future hospital claims are paid above the Medicare rate. In addition, IHS could review the claims that we determined were overpaid to pinpoint specific problem areas that led to overpayments.

IHS Should Provide Technical Assistance to Tribes To Ensure Proper Payments of Hospital Claims

We found that tribes paid \$860,000 over the Medicare rate for hospital claims. IHS should provide tribes with technical assistance in determining the Medicare rate for hospital claims. Because IHS receives limited information from tribes, it should determine why tribes paid over the Medicare rate. It can determine this using a variety of techniques. We have sent IHS basic service information about tribal claims paid over the Medicare rate. IHS could review these claims to pinpoint specific problem areas that led to

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overpayments. In addition, it could survey tribes to determine their challenges and successful practices in determining the Medicare rate.

Once IHS determines potential barriers to proper payments, IHS could develop guidance to prevent future overpayments. For example, it could share the identified challenges and successful practices with all tribes.

IHS Should Seek Legislative Authority To Cap Payments for CHS Nonhospital Services

Historically, IHS and tribes have had difficulty negotiating low rates for CHS due to the relatively small number of American Indians and Alaska Natives and because there are few private providers in rural areas. The passage of the MMA provision helped ensure lower rates for hospital services. A separate provision may be necessary to ensure lower rates for nonhospital services. Whatever method IHS uses to cap payments reasonably and accurately should be determined after careful determination of the impact of the new rates on the provider community, as well as other potential barriers to implementing the new rates.

One option would be to extend Medicare rate requirements to nonhospital services. We have shown that IHS and tribes would have realized considerable savings if they had paid at the Medicare rate for nonhospital services. In fact, IHS and tribes could have saved up to \$13 million if nonhospital claims were capped at Medicare rates. These savings could also have paid for nonhospital claims for American Indians and Alaska Natives who might otherwise be denied CHS health-care services.

IHS could also pursue other methods to cap payments to nonhospital providers. For instance, IHS could create a national fee schedule for nonhospital CHS services or adapt other, existing payment methodologies for health-care services.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

IHS concurred with all four of our recommendations. IHS also noted two potential weaknesses with the pricing software that we used to calculate Medicare rates for hospital outpatient claims. We did not make any changes to the report based on IHS's comments. For the full text of IHS's comments, see Appendix C.

R E C O M M E N D A T I O N S

In response to our first recommendation, that IHS and tribes take appropriate action regarding overpaid CHS hospital claims, IHS stated that it will direct the fiscal intermediary to review the claims identified by OIG as overpaid and, where appropriate, initiate refunds.

In response to our second recommendation, that IHS direct its fiscal intermediary to ensure that all future CHS hospital claims are paid at or below the Medicare rate, IHS stated that it will instruct the fiscal intermediary to conduct random claims sampling for financial and claims processing accuracy. The findings from these monthly audits will be submitted to IHS and used to track improvement in this area.

In response to our third recommendation, that IHS provide technical assistance to tribes to ensure proper payments of hospital claims, IHS stated that a thorough review of our report, along with any additional agency findings, will enable IHS to tailor training to address claims identified as overpaid and provide guidance to help tribes more consistently calculate claims payments in accordance with regulations.

In response to our fourth recommendation, that IHS seek legislative authority to cap payments for CHS nonhospital services, IHS stated that it will continue to meet with tribes and tribal organizations to develop a plan to cap payments for nonhospital services.

IHS noted that the MediRegs Ambulatory Payment Classification software OIG used to calculate outpatient hospital claims payment does not include outlier payments or the 7.1-percent add-on for rural sole community hospitals. OIG recognizes that some differences in the Medicare price may be attributed to different pricing software.

Specifically, we acknowledge, in the limitations section, that when determining the Medicare rate for sampled claims, we priced the services as they were coded and did not attempt to check the accuracy of the coding. Thus, we could not identify outlier payments.

We also acknowledge, in the limitations section, that we did not take shortage or scarcity area bonuses into account when calculating the Medicare rate for hospital claims. This could have caused the total Medicare payments for claims in these areas to be slightly higher than the Medicare rate we calculated.

DETAILED METHODOLOGY

Sample

We pulled a stratified random sample of 800 claims. The four strata were: Indian Health Services (IHS) hospital, tribal hospital, IHS nonhospital, and tribal nonhospital. We further stratified by the amount paid. We categorized paid amounts as small, medium, or large. See Table A-1 for claims sampled by strata.

Table A-1: Stratified Sample Structure

Stratum Description	Small Claims: Population	Medium Claims: Population	Large Claims: Population	Small Claims: Sample	Medium Claims: Sample	Large Claims: Sample	Total Number of Claims per Stratum
Hospital claims	Paid amount <=\$1,000	Paid amount \$1,000.01–\$10,000	Paid amount >\$10,000	Paid amount <=\$1,000	Paid amount \$1,000.01–\$10,000	Paid amount >\$10,000	
IHS hospital	8,748	2,587	443	65	65	70	200
Tribal hospital	5,973	1,526	193	65	65	70	200
Nonhospital claims	Paid amount <=\$500	Paid amount \$500.01–\$4,000	Paid amount >\$4,000	Paid amount <=\$500	Paid amount \$500.01–\$4,000	Paid amount >\$4,000	
IHS nonhospital	25,475	7,919	996	65	65	70	200
Tribal nonhospital	22,119	3,711	353	65	65	70	200
Total	62,315	15,743	1,985	260	260	280	800

Source: Office of Inspector General (OIG) analysis, 2009.

Data Collection

We collected paid claims from the Contract Health Services (CHS) program for services delivered between January and March 2008. We chose this period for two reasons. First, most claims during this period should have been processed and paid by the time we requested them in October 2008. Second, limiting our scope to 3 months lessened the resource burden on IHS and tribes, while providing a reliable snapshot of CHS payments.

We selected claims for services delivered during this period rather than claims paid in this period to ensure that all claims were covered under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provision. There is a delay between when services are provided and when IHS and tribes pay the claim. Thus, hospital claims paid during this time may have been for

services delivered prior to July 2007 and thus not covered by the MMA provision.

Data Analysis

For each analyzed claim, we calculated the Medicare rate for each line item. A claim can have multiple line items representing separate services provided in one provider visit. Next, we added the Medicare rate for each line item to determine the total Medicare rate for the claim and compared that to the total CHS payment for the claim.

We could not analyze 84 of the 800 claims in our sample. Of these, 56 were for services that were outside of our scope. For instance, they did not have a corresponding Medicare rate or were outside of our time period. The remaining claims were missing information needed to determine a Medicare rate, such as service codes.

Twenty-three sampled claims were incorrectly labeled hospital or nonhospital and thus placed in an incorrect stratum. We recognized that they were incorrect by the type of bill or the provider name. We analyzed these claims in their correct strata. This explains why there are more IHS hospital claims analyzed than sampled. See Table A-2 for the number of claims analyzed and the number removed from analysis in each of the four strata.

Table A-2: Claims Analyzed and Removed From Analysis Within Each Stratum			
Stratum of Claims	Sampled	Analyzed	Removed From Analysis
IHS hospital	200	205	0
Tribal hospital	200	169	35
IHS nonhospital	200	182	13
Tribal nonhospital	200	160	36
Total	800	716	84

Source: OIG analysis of CHS claims, 2009.

Determining the Medicare rate for hospital services. We used separate methods to determine the Medicare rate for hospital inpatient services, hospital outpatient services, and services provided in cost-based hospitals.

To determine the Medicare rate for inpatient services, we used the Centers for Medicare & Medicaid Services’ (CMS) Inpatient Prospective Payment System. We used this system because IHS recommended it. In addition, we referenced IHS guidance on determining a Medicare rate for hospital inpatient services.

To determine a Medicare rate for outpatient services, we used MediRegs' Ambulatory Payment Classifications (APC) pricing software. It calculates a Medicare rate for outpatient claims based on the service code, provider name, and date of claim. We included copayments when determining the Medicare rate for hospital outpatient claims because the CHS program covers all costs of the visit, including copayments. We also took into account all modifiers and status indicators, relying on CMS manuals and MediRegs data to determine how they affected the Medicare rate.

MediRegs' APC pricing software only accounts for hospital outpatient services with an APC code. For other services on a hospital outpatient claim, we referenced the corresponding fee schedule, such as the clinical laboratory fee schedule and the durable medical equipment fee schedule. We chose MediRegs because the company has a history of providing support to Government entities, including the National Institutes of Health Library.²¹ According to MediRegs, more than 800 hospitals and thousands of health-care professionals also use MediRegs pricing software.²²

To determine the Medicare rate for cost-based hospitals, we used the per-diem and cost-to-charge rates from the most recently settled cost report. We received these rates from the IHS fiscal intermediary. Some new critical-access hospitals in our sample did not yet have a settled cost report. This occurred for 12 hospital claims. For these hospitals, we used the amount that IHS or tribes paid as the Medicare rate.

Controlling for the provider wage index. The Medicare rate changes at various times throughout the year when a provider's wage index changes. Therefore, we controlled for wage index changes when determining the Medicare rate for inpatient and outpatient claims.

For inpatient claims, we priced each claim using the two different versions of CMS's 2008 Inpatient Prospective Payment System. Because we sampled based on service date, we do not know when IHS or tribes paid for each claim and thus what version of the Inpatient

²¹ Federal Business Opportunities, "Medi-regs Database." Available online at: https://www.fbo.gov/index?s=opportunity&mode=form&id=b36a4365c874323eba878548dd6f4b5b&tab=core&_cvview=0. Accessed on April 7, 2009.

²² MediRegs, "Our Clients: Testimonials." Available online at <http://www.mediregs.com/clients/our-clients>. Accessed on April 6, 2009.

Prospective Payment System was used. Therefore, we determined that the claim was paid at the Medicare rate if the amount paid matched either version of the Medicare rate. If the amount paid did not match either version, we determined the Medicare rate using the pricing software in effect between January and October 2008.

For outpatient claims, we priced each claim using both the 2008 and 2009 MediRegs' APC pricing software. MediRegs updates the outpatient pricer annually to account for wage index changes. We took a conservative approach and accepted the amount paid as the Medicare rate if it fell within 2008 and 2009 prices. If the amount paid was not within that range, we compared the amount paid to the 2008 Medicare rate.

Determining the Medicare rate for nonhospital services. Each type of nonhospital service required a different process to determine the Medicare rate. For physician services, we used MediRegs' Relative Value Unit calculator to determine the Medicare rate. We took into account all modifiers on the claims, relying on CMS manuals to determine how physician modifiers affect the Medicare rate. For all other nonphysician services, we used the appropriate source to determine the Medicare rate. See Table A-3 for the systems that we used to determine the Medicare rate for nonhospital services.

Table A-3: Identifying the Medicare Rate for Nonhospital Services

Nonhospital Service	CMS Pricing Source, 2008
Anesthesiologist	Anesthesia base units and conversion factor
Ambulance	Ambulance fee schedule
Durable medical equipment	Durable medical equipment fee schedule
Ambulatory surgical center	Ambulatory surgical center fee schedule and MediRegs' ambulatory surgical center wage index
Independent laboratories	Clinical laboratory fee schedule
End-stage renal disease center	End-stage renal disease center prospective payment calculator

Source: OIG analysis of the systems used for determining the Medicare rate, 2009.

ESTIMATES AND CONFIDENCE INTERVALS

See Tables B-1–B-4 for the point estimates and confidence intervals for the results discussed in the first finding.

Table B-1: Hospital Claims Paid At, Below, and Above the Medicare Rate

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of hospital claims paid above the Medicare rate	374	22.0%	16.1%–27.9%
Percentage of hospital claims paid at or below the Medicare rate	374	78.0%	72.1%–83.9%
Percentage of hospital claims paid at the Medicare rate	374	59.4%*	52.4%–66.3%
Percentage of hospital claims paid below the Medicare rate	374	18.7%*	13.2%–24.1%

* Numbers do not add up to exactly 78.0 due to rounding.

Source: Office of Inspector General (OIG) analysis of hospital claims, 2009.

Table B-1a: Indian Health Service Hospital Claims Paid At, Below, and Above the Medicare Rate

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of Indian Health Service (IHS) hospital claims paid above the Medicare rate	205	18.7%	11.5%–25.9%
Percentage of IHS hospital claims paid at or below the Medicare rate	205	81.3%	74.1%–88.5%

Source: OIG analysis of IHS hospital claims, 2009.

Table B-1b: Tribal Hospital Claims Paid At, Below, and Above the Medicare Rate

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of tribes' hospital claims paid above the Medicare rate	169	29.1%	18.7%–39.5%
Percentage of tribes' hospital claims paid at or below the Medicare rate	169	70.9%	60.5%–81.3%

Source: OIG analysis of tribes' hospital claims, 2009.

Table B-2: Dollars Spent on Hospital Claims

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Dollars spent above the Medicare rate for hospital claims	80	\$1.1 million	\$0.8 million–\$1.4 million
Dollars spent on hospital claims	374	\$32.8 million	\$29.6 million–\$36.0 million
Average Medicare rate per claim	374	\$1,907	\$1,691–\$2,124
Average amount overpaid among hospital claims paid above the Medicare rate	80	\$280	\$179–\$382
Tribes' dollars spent above the Medicare rate for hospital claims	48	\$860,446	\$585,443–\$1.1 million
IHS dollars spent above the Medicare rate for hospital claims	32	\$230,682	\$139,931–\$321,432
Tribes' average amount overpaid among hospital claims paid above the Medicare rate	48	\$534	\$363–\$705
IHS average amount overpaid among hospital claims paid above the Medicare rate	32	\$101	\$61–\$141

Source: OIG analysis of hospital claims, 2009.

Table B-3: Hospital Claims Paid Over the Medicare Rate by Type of Claim

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percent of overpaid claims that were outpatient	80	90.5%	86.2%–94.7%
Percent of overpaid claims that were inpatient	80	9.5%	5.3%–13.8%
Percentage of outpatient claims that were paid over the Medicare rate	174	24.0%	17.2%–30.9%
Percentage of inpatient claims that were paid over the Medicare rate	200	12.0%	6.1%–18.0%

Source: OIG analysis of hospital claims, 2009.

Table B-4: Dollars Spent Over the Medicare Rate for Outpatient Claims

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Dollars spent above the Medicare rate for outpatient services	174	\$751,633	\$468,218–\$1.0 million

Source: OIG analysis of hospital claims, 2009.

See Tables B-5–B-7 for the point estimates and confidence intervals for the results discussed in the second finding.

Table B-5: Dollars Spent on Nonhospital Claims

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Dollars spent above the Medicare rate for nonhospital claims	273	\$13.1 million	\$11.4 million–\$14.9 million
Dollars spent below the Medicare rate for nonhospital claims	36	\$3.2 million	\$500,000–\$5.9 million
Dollars spent on nonhospital claims	342	\$28 million	\$25.3 million–\$30.7 million
Average overpaid among nonhospital claims above the Medicare rate	273	\$327	\$281–\$374
Average Medicare rate	342	\$321	\$256–\$386

Source: OIG analysis of nonhospital claims, 2009.

Table B-6: Nonhospital Claims Paid At, Below, and Above the Medicare Rate

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of nonhospital claims paid above the Medicare rate	342	71.4%	64.6%–78.2%
Percentage of nonhospital claims that were paid at or below the Medicare rate	342	28.6%	21.9%–35.4%
Percentage of nonhospital claims paid at the Medicare rate	342	14.0%	8.8%–19.1%
Percentage of nonhospital claims paid below the Medicare rate	342	14.6%	9.5%–19.7%

Source: OIG analysis of nonhospital claims, 2009.

Table B-6a: IHS Nonhospital Claims Paid At, Below, and Above the Medicare Rate

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of IHS nonhospital claims paid above the Medicare rate	182	71.2%	62.1%–80.3%
Percentage of IHS nonhospital claims paid at or below the Medicare rate	182	28.8%	19.7%–37.9%

Source: OIG analysis of IHS nonhospital claims, 2009.

Table B-6b: Tribal Nonhospital Claims Paid At, Below, and Above the Medicare Rate

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of tribes' nonhospital claims paid above the Medicare rate	160	73.3%	63.1%–83.5%
Percentage of tribes' nonhospital claims paid at or below the Medicare rate	160	26.7%	16.5%–36.9%

Source: OIG analysis of tribes' nonhospital claims, 2009.

Table B-7: Payments for Physician Services

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of nonhospital claims paid over the Medicare rate that were for physician claims	273	90.8%	87.1%–94.5%
Percentage of all nonhospital claims that were for physician claims	342	88.4%	84.5%–92.3%

Source: OIG analysis of nonhospital claims, 2009.

AGENCY COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

AUG 7 2009

Indian Health Service
Rockville MD 20852

TO: Inspector General
FROM: Director
SUBJECT: Comments by the Indian Health Service on the OIG Draft Report "IHS Contract Health Services Program: Overpayments and Potential Savings," (Report No. OEI-05-08-00410)

The purpose of this memorandum is to respond to your July 8 memorandum transmitting the Office of Inspector General (OIG) draft report entitled, "IHS Contract Health Services (CHS) Program: Overpayments and Potential Savings" (OEI-05-08-00410). I appreciate the opportunity to address your recommendations and the following provides the Indian Health Service's (IHS) comments on the draft report.

IHS Response to the OIG Draft Recommendations

1. The IHS and Tribes should take appropriate action regarding overpaid CHS hospital claims.

The IHS concurs with this recommendation. The Agency will direct our Fiscal Intermediary (FI) to review the claims identified by the OIG as overpaid, and where appropriate, initiate refunds in accordance with the Debt Collection Procedures Act within one month of receipt of the final report. In addition, the IHS will review and monitor the FI's claims processing and payment policies, procedures, and pricing software accuracy, to ensure that all claims processed during the time period under review (January through March 2008) have been paid in accordance with the Medicare-Like Rate (MLR) requirements.

In September 2008, following the June 4, 2007, *Federal Register* publication of a joint IHS/Center for Medicare & Medicaid Services (CMS) final rule entitled, "Section 506 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 - Limitation on Charges for Services Furnished by Medicare Participating Inpatient Hospitals to Individuals Eligible for Care Purchased by Indian Health Programs" (72 FR 30706), the IHS provided CMS with a memorandum clarifying Agency interpretation of the MLR regulations." For your review, I have included a copy of the memorandum transmitted to CMS under Tab A.

The IHS memorandum detailed the benefits coordination methodology under the final rule as specified in the *Code of Federal Regulations* (CFR), Subpart D, §136.30 ("Payment to Medicare-participating hospitals for authorized Contract Health Services" 42 CFR 136.30).

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Consistent with the Medicare program, the IHS coordinates benefits under 42 CFR 136.30(g) in a manner similar to the Medicare Secondary Payor requirements at 42 CFR, Part 411, “Exclusions From Medicare And Limitations On Medicare Payment.” The maximum payment by the IHS is only that portion of the payment amount determined under 42 CFR 136.30 not covered by any other payor. In other words, the maximum payment by Indian Health Service/Tribal/Urban (I/T/U) programs will not exceed the MLR to ensure consistency with the Medicare program. The total payment to providers, including applicable cost sharing, will not exceed the MLR in accordance with regulations. The Agency received several calls from hospitals regarding this change.

The absence of complete claims data at this stage of the review process makes it difficult for the IHS to identify specific payment errors or patterns of payment errors. I note that the OIG's draft report indicates the methodology used included the 2009 MediRegs Ambulatory Payment Classification software to calculate outpatient hospital claims payment. This version of the software does not include outlier payments or the 7.1 percent add-on for rural sole community hospitals for the hold harmless adjustments. Payment calculations made by our FI currently include these factors.

2. The IHS should direct its FI to ensure that all future CHS hospital claims are paid at or below the Medicare rate.

The IHS concurs with this recommendation. The Agency has directed the FI to ensure all current and future claims are paid at or below the Medicare rate. The FI has multiple, redundant quality assurance edits built into the claims processing software to capture routinely occurring errors, such as incorrect billing by providers, data entry mistakes, and Agency-specific edits. The IHS will continue to monitor the FI's claims processing performance to ensure all claims are paid in accordance with regulations. The IHS will instruct the FI to conduct random claims sampling for financial and claims processing accuracy. The findings from these monthly audits will be submitted to the IHS and used to track improvement in this area.

3. The IHS should provide technical assistance to Tribes to ensure proper payments of hospital claims.

The IHS concurs with this recommendation. Once this draft report is finalized, its findings and recommendations will be shared with the Tribes. A thorough review of the final report, along with any additional Agency findings, will enable the Agency to tailor training to address claims identified as overpaid and provide guidance to help Tribes more consistently calculate claims payments in accordance with the MLR regulations. Technical assistance will be provided to Tribes through the Agency's CHS program, which will allow us to identify problem areas and provide guidance on the process for seeking refunds for claims paid in excess of MLR requirements. The IHS CHS program conducts annual training seminars for both Federal and Tribal staff on these and related topics and provides specialized training on changes to

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regulations, with demonstrations detailing how to calculate different Medicare reimbursement methodologies.

In June 2008, the Agency released an IHS-developed Web site entitled, "Medicare-Like Rates Information," to provide Tribes and Tribal organizations with an overview of the regulatory changes, along with other technical resources. Information available from the Web page includes the following: MLR Frequently Asked Questions; sample provider letter to assist Tribal organizations in notifying providers of rate changes; useful links to regulations, relevant CFR sites, etc. The Web site address is <http://www.ihs.gov/nonmedicalprograms/mlri/>.

Throughout this year and 2010, in conjunction with other Agency training seminars currently being planned, this topic will be included as a reoccurring agenda item.

Attached at Tab B is the agenda for the most recently scheduled CHS Training Seminar, held May 12 through 15, 2009, in Denver, Colorado, and MLR Web site information.

4. The IHS should seek legislative authority to cap payments for CHS nonhospital services.

The IHS concurs with this recommendation. The Agency realizes the potential benefits of extending the Medicare Prescription Drug, Improvement and Modernization Act of 2003 regulations and has been discussing this and related issues with Tribes at various large-scale meetings, such as the Direct Services Tribes and the National Indian Health Board Conference. The IHS will continue to meet with Tribes and Tribal Organizations to develop a plan to cap payments for nonhospital services.

Thank you for allowing the IHS to provide comments on the OIG's draft report.

/s/

Yvette Roubideaux, M.D., M.P.H.

Attachments

Tab A September 17, 2008 Memorandum to CMS "Clarification for Medicare-Like Rate Regulation

Tab B May 12-15, 2009 CHS Training Seminar Agenda and MLR Web site information



A C K N O W L E D G M E N T S

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Thomas Komaniecki, Deputy Regional Inspector General.

Anne Bracken served as the team leader for this study and Beth McDowell served as the lead analyst. Other principal Office of Evaluation and Inspections staff from the Chicago regional office who contributed to the report include Di Zhang; other central office staff who contributed include Robert Gibbons and Talisha Searcy.