CONNIE WHIDDEN, HEALTH DIRECTOR
SEMINOLE TRIBE OF FLORIDA

TESTIMONY BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE HEARING ON
PROMISES MADE, PROMISES BROKEN: THE IMPACT OF CHRONIC UNDERFUNDING OF CONTRACT HEALTH SERVICES.

December 3, 2009

Chairman Dorgan, Vice Chairman Barrasso, and Members of the Committee, good afternoon and thank you for the opportunity to be here today. My name is Connie Whidden. I am a Member of the Seminole Tribe of Florida and have served as the Health Director for the Tribe, which is headquartered in Hollywood, Florida, for 15 years. I have been asked to provide testimony on the Tribe's experience of having to supplement our Contract Health Service (CHS) program with tribal resources due to chronic underfunding from IHS. I have also been asked to describe the recent problems we encountered when Medicare began to deny claims of tribal members who receive this supplemental coverage despite Indian Health Service (IHS) regulations which make CHS the payer of last resort.

The Tribe's CHS Program

The Seminole Tribe of Florida currently has a compact of self-governance with the IHS under Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA). For decades, the Tribe has directly operated its own health programs. We offer primary care programs at the ambulatory clinics located on our reservations, and we also operate the CHS program through which we purchase health care services that are otherwise not available to our patients at the Tribe's clinics. Based on patient eligibility for CHS, the Tribe authorizes CHS from certain specified providers, normally on referral, based on medical necessity, priority of need and funding availability for such services.

In the past, these outside health care providers have been paid first by private insurance or by Medicare and Medicaid when applicable, and thereafter by the Tribe's CHS program. The Tribe's CHS program is responsible for payment only after all of a patient's other alternate resources are exhausted.

Chronic CHS Under-Funding and Tribal Supplementation of CHS

The status of CHS funding nation-wide is woefully inadequate and many tribes – including the Seminole Tribe of Florida – struggle to provide CHS services when the funding runs out mid-way through the fiscal year. This past year, for example, the Tribe received approximately $1.9 million for its CHS program from IHS, excluding CHEF fund reimbursements. These funds are very limited and they failed to meet our members' CHS needs. In fact, if we had relied solely on these funds we would have had to stop providing CHS services by the end of the first quarter of the fiscal year. Instead, the

Tribe chose to supplement these IHS CHS funds with $36 million of its own to ensure that eligible tribal members receive the care they need through out the year.

Because the CHS unmet need is so great, the Tribe created a supplemental plan through which the Tribe annually funds the unmet need. The Tribe funds and administers the plan itself. Eligibility for this supplemental coverage is limited to tribal members and descendants who are eligible for the CHS program. Consistent with IHS regulations, all beneficiaries must enroll in other programs for which they are eligible – such as Medicare and Medicaid – in order to be eligible for services paid for by CHS, including the Tribe's supplement to CHS. The Tribe's plan is an integral part of our CHS program.

CMS Incorrectly Issues Denials of Payment

Under federal regulations,[1] the CHS program is residual to all other payers, including Medicare and Medicaid. This is the "payer of last resort rule," and is extremely important because CHS funding is so scarce. This rule also assures that Indian people enrolled in Medicare and Medicaid can fully utilize these benefits to the same extent as non-Indians enrolled in those programs – without having the value of those benefits diminished to secondary status by the rights and benefits they receive by virtue of their status as Indian people to whom the United States owes a trust obligation.

Because the Tribe's plan supplements its overall CHS program, we believe that Medicare should be the primary payer for services provided to a beneficiary enrolled in Medicare. In other words, the CHS program continues to be the payer of last resort and that rule does not change merely because the Tribe has supplemented its under-funded CHS program with tribal funds. The Tribe's plan explains that it is supplemental to and part of the Tribe's CHS program and that the plan will always act as the payer of last resort whenever a person has other insurance coverage, including Medicare and Medicaid.

After our supplemental plan was established, Medicare paid first for care to tribal members enrolled in Medicare. But approximately 18 months ago Medicare began denying claims from patients covered by our supplemental plan. The denials were primarily based on what is known as "Reason Code 34294," which means that the claims must be billed to an available employer group health plan. Upon inquiry, we learned that the denials were based on an erroneous view that the Tribe's CHS supplemental plan is an employee benefit plan to which CMS is a secondary payer.

For example, a Tribal member who is enrolled in Medicare is in end-stage renal disease and is undergoing dialysis treatments. Medicare approved the claims early in the treatment, but thereafter started to deny payment asserting that the patient has another resource – namely the Tribe's supplemental plan which Medicare erroneously characterizes as an employment-based plan.

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[1] 42 DFR §136.61.

The patient has appealed the denied claims, but in the meantime the Tribe has paid the provider more than $500,000 to assure the patient has continued access to dialysis services. The Tribe has also worked out temporary payment arrangements with other service providers with the understanding that the Tribe would be repaid once the problems are resolved with Medicare.

The Tribe's Efforts To Reverse Denials

The Tribe has tried to work with Medicare staff at the local level to reverse these erroneous denials. When our efforts to achieve correction at the local and regional level failed, we sought assistance from Jonathan Blum, the Director of the Center for Medicare Management. Tribal Chairman Mitchell Cypress wrote to Mr. Blum last August, providing a detailed explanation of the issue and rationale for why the CHS payer of last resort should continue to apply for Seminole Tribal members receiving care through the CHS program. He asked that Mr. Blum meet with Tribal representatives to resolve the issue. I have attached that letter to my statement and ask that it be included in the official hearing record.

After three months of phone calls and emails to follow up on our meeting request, Tribal officials recently met with Gerald Walters, Director of CMS' Financial Services Group, to pursue the matter Mr. Walters apologized for the delay in responding to the Seminole Tribe, and pledged to resolve the issue promptly. We explained to Mr. Walters that the Tribe's CHS supplemental health plan is not an employment-based "group health plan" as that term is defined in the MSP rules and in the Social Security Act, so the Medicare Secondary Payer (MSP) rules regarding group health plans are not a basis for denial of Medicare payments. "Group health plans," to which Medicare benefits are secondary, pertains primarily to insurance being provided in an employment-based context. Mr. Walters told us that CMS considers "group health plans" under the MSP rules to include a variety of relationships that are not limited to employer-employee types of plans, like the Tribe's member plan. We have not, however, been able to find any substantiation for this position in the applicable law or CMS regulations.

We explained that the Tribe's plan supplements the CHS program which is the payer of last resort under Federal regulations. These regulations require that all alternate resources must be accessed and used before the CHS program will be responsible for any payment. While it is generally unquestioned that Medicare is the primary payer when CHS is involved, applicable regulations are not being honored with respect to our supplemental plan.

Resolution of the problem was not achieved at the meeting with Mr. Walters, but he did agree to consult with IHS officials to learn more about the CHS program and the payer of last resort policy before making a final determination on the Tribe's request to correct the denied Medicare claims. We understand that CMS-IHS conversations have begun.

Conclusion

Mr. Chairman, the real issue we are confronting here is whether the federal government will honor its trust responsibility to pay for medically necessary services provided to Tribal members through the CHS program as administered by the Seminole Tribe pursuant to its self-governance agreement. The current discussions between CMS and IHS are taking place to reconcile apparent inconsistencies between CMS regulations governing Medicare and IHS regulations governing the CHS program.

We believe that the correct legal conclusion is that Medicare is the primary payer in the circumstances described above. If CMS reaches a different conclusion, we believe it is the responsibility of the Congress to consider the broader policy implications at stake. As part of its trust responsibility to Indian tribes the Federal government has the obligation to provide health care to Indian people. If Medicare will not pay for necessary medical care for Seminole tribal members because the Seminole Tribe has stepped in to supplement the CHS program, it will be yet another example of the United States failing to meet its trust responsibility to Indian people.

Our Tribe is not the only tribe that supplements inadequate CHS funding levels. All tribes who can afford to do this do it because they want to advance the health status of Indian people. Our efforts should be encouraged, not discouraged. We and other tribes should not suffer adverse consequences when we attempt to do the right thing. It goes without saying that if CHS were fully funded, tribes would not be placed in the position of having to do the Federal government's job for it. To ensure that the United States' trust responsibility to Indian people for health care is fully realized the CHS program should be an entitlement program.

Until that happens, however, we urge Congress to take whatever steps are necessary to assure that the Federal government does not further abrogate its trust responsibility to Indian people by denying Medicare benefits to tribal members because tribal governments take steps to supplement woefully inadequate CHS funding levels. If existing law can be interpreted to allow CMS to deny Medicare benefits on this basis, then the law needs to be clarified to assure that this practice does not continue.

I hope that CMS will quickly determine that Medicare is the primary payer for Seminole Tribal members whose claims have been denied. If it does not, I look forward to working with this Committee and the Congress as a whole to address this issue, which has significance not just for the Seminole Tribe, but for all of Indian Country.

Thank you for the opportunity to testify today. I will be happy to answer any questions you may have.

Attachment

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August 21, 2009

Via Telefax and U.S. Mail

Jonathan D. Blum, Director
Center for Medicare Management
DHS/CMS/OA
200 Independence Avenue
Washington, D.C. 20201

Re: Medicare As Primary Payer

Dear Mr. Blum:

The Seminole Tribe of Florida ("STOF") is seeking your assistance to resolve an outstanding issue involving coordination of benefits between the STOF and Medicare. The STOF believes that several Medicare claims have recently been denied by the Centers for Medicare and Medicaid Services ("CMS") based on an improper application of the Medicare secondary payor rules to the STOF's health care beneficiaries. The STOF thinks the law is clear that Medicare is the primary payer in the situations at issue and that the claims should not have been denied. Any help you could provide to resolve this matter would be greatly appreciated.

We begin by providing the background giving rise to our request and then outline our view of the relevant issues:

Background

As you know, the United States has a trust responsibility to provide health care to Indians. Generally, this responsibility is performed by the Indian Health Service ("IHS") which carries out Indian health programs with annual appropriations from Congress. But Federally-recognized tribes – such as the STOF – may elect to take over operation of their IHS health programs under agreements issued pursuant to the Indian Self-Determination and Education Assistance Act ("ISDEAA"), utilizing funding supplied by IHS.

The STOF has directly operated its health program for decades and currently does so under a compact of self-governance authorized by Title V of the ISDEAA. It offers primary care programs at the ambulatory clinics on its reservation, and operates the Contract Health Services ("CHS") program through which IHS and tribes purchase health care services that are not available in the Indian health care facilities.

Under federal regulations, the CHS program is residual to all other payers, including Medicare. This policy is extremely important because CHS funding is so scarce. Of equal importance, however, is the fact that these regulations assure that Indian people enrolled in Medicare can fully utilize their Medicare benefits to the same extent as non-Indians enrolled in that program without having the value of those benefits diminished to secondary status by the rights/benefits they received by virtue of their status as Indian people to whom the United States owes a trust obligation.

Because the CHS funding the STOF receives from the IHS is so limited and the unmet need is so great, the STOF determined that it had to supplement its meager CHS budget to assure that Tribal beneficiaries can receive the level of care to which they are entitled. The STOF created a self-funded supplemental plan for which its members and descendants are eligible (hereinafter "STOF self-funded member health plan"). It is intended to supplement the CHS program.

Since its self-funded member health plan is supplemental to CHS, the STOF believes that, like the CHS program itself, Medicare is the primary payer when a beneficiary is enrolled in Medicare. The STOF self-funded member health plan, as a supplement to the CHS program and consistent with the Tribe's Compact and Funding Agreement with the IHS, is responsible for payment only after all of a patient's other alternate resources are exhausted. The Plan Document for the STOF self-funded member health plan explains that whenever a person covered by the plan has other insurance coverage, including Medicare and Medicaid, the plan will always act as the payer of last resort.

Recently, however, CMS denied Medicare benefits to patients who received CHS services authorized by the STOF because those patients also happen to be covered by the STOF self-funded member health plan. The denials were based on the erroneous view that the STOF self-funded member health plan is an employee benefit plan to which CMS is a secondary payor. For example, one recent denial of Medicare coverage was based on "Reason Code 34294," where CMS said the "claim submitted as Medicare primary and a positive ESRD/EGHP record exists . . . claim should be billed to the employer group health plan."

The STOF believes the denials were incorrectly issued and that Medicare should be considered the primary payer when the STOF's CHS eligible beneficiaries receive CHS services. For the past few months Tribal staff has been engaged in discussions with CMS staff to seek resolution on this issue. The STOF has worked with Diane Thorton, the CMS Native American contact for the Atlanta Region, and Rodger Goodacre, a member of the CMS Tribal Affairs Group. While these individuals have provided helpful information, they and the STOF have to date not been able to resolve the outstanding denials. We understand the issue is being reviewed internally at CMS but without any input from the STOF.

Discussion

The STOF believes that its self-funded member health plan is residual to Medicare for two reasons: (1) The Tribe's self-funded member health plan is not a "group health plan," ("GHP") so the Medicare secondary payer rules regarding GHPs do not apply; and (2) The STOF's self-funded member health plan supplements the STOF's CHS program in which the STOF is the payer of last resort. We address each of these reasons in greater detail below.

1. The Medicare secondary payer rules do not require denial based on the STOF's self-funded member health plan.

Section 1862 of the Social Security Act makes Medicare the secondary payer for services to the extent payment has been made or can reasonably be expected to be made under a group health plan, large group health plan, workers' compensation plan, liability insurance or no fault insurance. 42 U.S.C. §§ 1395y(b)(1)(A)(i), (v), 1395y(b)(2)(A). The basic rule is stated in the CMS regulations as follows: "Medicare benefits are secondary to benefits payable by a primary payer even if State law or the primary payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries." 42 C.F.R. § 411.32 (emphasis added). The term "primary payer" in the context of that regulation means an entity that is responsible for payment under a "primary plan," which in turn is defined as a group health plan, a worker's compensation law or plan, an automobile or liability insurance policy or plan, or no-fault insurance. 42 C.F.R. § 411.22

Because the STOF self-funded member health plan is not workers' compensation, liability insurance or no fault insurance, the question is whether it constitutes a GHP for purposes of applying the Medicare secondary payer rule. The answer is that the STOF self-funded member health plan is not a GHP.

The term "GHP" is defined at Section 1862 of the Social Security Act as follows: "[T]he term 'group health plan' has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of Title 26." 42 U.S.C. § 1395y(b)(1)(A)(v). Section 5000(b) of the Internal Revenue Code in turn defines GHP as follows: "[A] plan . . . of, or contributed to by, an employer . . . or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families." 26 U.S.C. § 5000(b). Thus, to be a GHP, there must be an employment relationship where the insurance is being provided to employees (current or former) and/or employees' families.

This employment-related definition is carried-forward by CMS in its regulations implementing the secondary payer rules: "Group health plan (GHP) means any arrangement made by one or more employers or employee organizations to provide health care directly or

through other methods such as insurance or reimbursement, to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families . . . ." 42 C.F.R. § 411.101. See also Medicare Secondary Payer Manual § 20 (Rev. 65, 03-20-09) ("The term "GHP" means any arrangement of, or contributed to by, one or more employers or employee organizations to provide health benefits or medical care directly or indirectly to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.").

The STOF self-funded member health plan is not a GHP because eligibility for enrollment is not at all related to employment with the STOF. The plan is provided by the STOF solely to its Tribal members and descendants of Tribal members to supplement an inadequately funded federal program. The plan is not contingent on or related in any way to employment with the STOF.

The STOF self-funded member health plan thus is not a GHP as that term is defined in the Social Security Act, the Internal Revenue Code, or CMS's regulations or policies implementing the Medicare secondary payer rules. As the CMS's Medicare Secondary Payer Manual recognizes, "A plan that does not have any employees or former employees as enrollees . . . does not meet the definition of a GHP and Medicare is not secondary to it." Manual § 20 (defining "GHP"). Accordingly, the STOF believes that the Medicare denials at issue – based on erroneously treating the STOF self-funded member health plan as a GHP – are incorrect.

2. The STOF is the payer of last resort.

As explained above, the STOF's self-funded member health plan is provided to STOF members and descendants in order to supplement the STOF's CHS program, which the STOF carries out under its Title V compact of self-governance and funding agreement with the Indian Health Service. The STOF's CHS program is intended to pay for health care services that are outside of the scope of services provided within the STOF's own health care facilities. Based on patient eligibility for CHS, the STOF authorizes CHS from certain specified providers, normally on referral, based on medical necessity, priority of need and funding availability for such services. However, like many other tribes around the country, STOF does not receive nearly enough CHS funds from the IHS to meet the need for CHS services. The STOF thus developed its self-funded member health plan in order to supplement the CHS program for STOF members and descendants.

Under the ISDEAA and the Tribe's Title V agreements with the IHS, the STOF has authority to redesign the programs it has assumed from the IHS, such as the CHS program, "in any manner which the STOF deems to be in the best interest of the health and welfare of the Indian community being served," so long as STOF does not deny eligibility for services in doing so. STOF Title V Self-Governance Compact, Art. III, § 4 (Amended and Restated FY 2004) (hereinafter "Compact"); FY 2009 Funding Agreement, § 4(c); 25 U.S.C. § 458aaa-5(e). The

STOF may also consolidate its Title V programs and the associated funds it receives in its funding agreement from the IHS with the STOF's own funds or funds from other sources, provided the programs are allowable for inclusion in the STOF's funding agreement. Compact, Art. III, § 9; 25 U.S.C. § 458aaa-5(e). The STOF accordingly exercised such authority when it created the STOF self-funded member health plan to supplement the CHS program and inadequate CHS funding with STOF funds. STOF is thus carrying-out the STOF self-funded member health plan as part of the Title V self-governance compact and funding agreement.

The STOF self-funded member health plan, as part of the STOF's CHS program, is the payer of last resort. The IHS regulations provide that all alternate resources must be accessed and used before the CHS program will be responsible for any payment:

(a) The IHS is the payor of last resort for persons defined as eligible for contract health services under the regulations in this part, notwithstanding any State or local law or regulation to the contrary.

(b) Accordingly, the IHS will not be responsible for or authorize payment for contract health services to the extent that:

(1) The Indian is eligible for alternate resources, as defined in paragraph (c) of this section, or
(2) The Indian would be eligible for alternate resources if he or she were to apply for them, or
(3) The Indian would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for contract health services, or other health services, from the IHS or IHS funded programs.

(c) Alternate resources means health care resources other than those of the IHS. Such resources include health care providers and institutions, and health care programs for the payment of health services -including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e., Medicare, Medicaid), State or local health care programs, and private insurance.

42 C.F.R. § 136.61(b)-(c).

CMS recognizes its position as primary payor when CHS is involved. For example, Section 50.1.5 of the CMS Medicare Benefit Policy Manual (Rev. 102, 02-12-09) states that "[i]n the case of such contract health services to Indians and their dependents entitled under the Indian Health Service (IHS) program and Medicare, Medicare is the primary payer and the IHS the secondary payer."

The STOF thinks that for CHS eligible beneficiaries of the STOF, who are covered by the STOF self-funded member health plan as supplemental to the STOF's CHS program, Medicare

is the primary payer for CHS services. The STOF's CHS program and self-funded member health plan are the payers of last resort.

Any other outcome would essentially penalize the Tribe for its "good deed" of stepping in to augment a vital federal Indian health program which has never been funded at the appropriate level of need, and would put the STOF in the position of subsidizing the Medicare program.

Conclusion

Because the STOF self-funded member health plan is not a GHP and the STOF is a payor of last resort, the STOF asks that CMS reverse its previous decisions to deny payment of claims to STOF beneficiaries under the Medicare secondary payer rules. The STOF asks for your assistance in clarifying this issue with CMS staff. We would like to work together with you to revisit the various denials of Medicare payment as soon as possible. Many of the provider bills for which Medicare issued denials have been pending for several months and need to be quickly resolved.

The STOF would appreciate it if you and your staff could meet with us as soon as possible so that we can discuss and resolve these issues. We will be in touch with your office to schedule a mutually agreeable time to meet. Thank you in advance for your time and attention to this important matter.

Sincerely,

Mitchell Cypress
Chairman of the Tribal Council

cc: Connie Whidden, Director, Health Administration, Seminole Tribe of Florida
Jim Shore, General Counsel, Seminole Tribe of Florida
Geoff Strommer, Esq.
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