106TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 106–818
Part 1

ALASKA NATIVE AND AMERICAN INDIAN DIRECT REIMBURSEMENT ACT OF 1999

SEPTEMBER 6, 2000.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. YOUNG of Alaska, from the Committee on Resources, submitted the following

R E P O R T

[To accompany S. 406]

[Including cost estimate of the Congressional Budget Office]

The Committee on Resources, to whom was referred the bill (S. 406) to amend the Indian Health Care Improvement Act to make permanent the demonstration program that allows for direct billing of medicare, medicaid, and other third party payors, and to expand the eligibility under such program to other tribes and tribal organizations, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

PURPOSE OF THE BILL

The purpose of S. 406 is to amend the Indian Health Care Improvement Act to make permanent the demonstration program that allows for direct billing of medicare, medicaid, and other third party payors, and to expand the eligibility under such programs to other tribes and tribal organizations.

BACKGROUND AND NEED FOR LEGISLATION

The purpose of S. 406 is to make permanent a direct billing demonstration program authorized by the Indian Health Care Improvement Act Amendments of 1988, Public Law 100–713. The bill makes the program permanent for the four demonstration programs and expands the eligibility to other tribes and tribal organizations which operate Indian Health Service (IHS) hospitals and clinics. It provides that all funds received through the program be used specifically to maintain accreditation or, if that has been secured, to address the lack of health resources available to that tribe. The bill recognizes the success of the demonstration program,

and that the program enhances and reinforces the ideas contained in the Indian Self-Determination and Assistance Act (Public Law 93–638, 25 U.S.C. 450 et seq.) to strengthen the government-to-government relationship between tribes and the federal government.

BACKGROUND

In exchange for the cession of millions of acres of land to which Indian tribes held aboriginal title, the United States entered into treaties with Indian nations. Many of the treaties provided that health care services would be guaranteed to the citizens of Indian country in perpetuity. The federal obligation for the provision of health care services in Indian country also arises out of the special trust relationship between the United States and Indian tribes, as reflected in Article I, Section 8, Clause 3 of the U.S. Constitution, which has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders.

In 1976, the Indian Health Care Improvement Act (IHCIA, Public Law 94–437, 25 U.S.C. 1601 et seq.) became law. IHCIA was the first comprehensive statute specifically addressing the provision of health care in Indian country and the federal administration of health care of Native Americans. In 1988, amendments to IHCIA provided for the creation of a medicare and medicaid direct billing demonstration program which is made permanent by this legislation.

THE IHS AND BILLING PRACTICES

Prior to 1988, tribes who operated IHS hospitals and clinics submitted their requests for reimbursement for medicare and medicaid outlays or expenditures to the IHS. The submission of that request began a complex, arduous process which did not always result in payment.

Once a patient was seen by the IHS facility, a claim was generated and sent to the IHS Area Office. The Area Office, in turn, made a claim to the Fiscal Intermediary, the agent responsible for processing medicare and medicaid claims (oftentimes a state). Once the Fiscal Intermediary paid the IHS Area Office, the funds were deposited in the federal reserve and sent to the Department of the Treasury, where payment was apportioned back to the IHS headquarters. The Area Office would then request funds from IHS headquarters, and once the amount an Area Office would receive was determined, the Area Office would modify the tribe's contract to reflect the actual amount received from IHS headquarters and which was to be paid to the tribe. When the payment was finally received by the tribe operating the IHS facility, it was always difficult, if not impossible, for the tribe to determine which of the submitted claims had been paid and which had been denied, as there was no list provided which identified claim numbers to the tribe. Often, according to tribal officials, if a payment register was received, it would not be for months or years after the original claim was made and no attempt could be made to resubmit the claim. Officials reported periods as long as two years between submission of a claim and reimbursement or denial of the claim.

Tribal officials also claimed that for a period of time the problems with a claim resulted from incorrect submissions made by the

IHS, whose computer system had malfunctioned. A medicare audit later uncovered the errors, and tribes were made to repay the overpayment claimed by the IHS system, along with penalties, even though they had no control over the submission to the Fiscal Intermediary, nor any way of determining that they had in fact received an overpayment.[1]

HISTORY OF THE DEMONSTRATION PROGRAM

In 1988, the Indian Health Care Improvement Act was amended to authorize a limited demonstration program for direct billing by tribes. In the course of gathering information regarding the IHCIA, several tribal leaders submitted comments regarding their desire to streamline the process for billing medicare and medicaid reimbursements. Specifically, Indian tribes and tribal organizations who contracted the operation and administration of IHS facilities stated that:

> should they be allowed to retain all of the funds they collect from Medicaid and Medicare reimbursements and third party insurers, they could better control their own cost accounting systems and accounts receivable, and that they could thereby maximize and increase the amounts collected from such sources. Tribes and tribal organizations believe that the policy of self-determination dictates this step toward a degree of financial autonomy that will better equip them to one day assume the full range of responsibilities that are associated with the provision of health care. Evidence submitted by tribal contractors in Alaska would indicate that because of certain legal impediments that exist to the collection of third party resources by the Indian Health Service, tribal contractors can in fact collect amounts from third party sources far in excess of the amounts that Indian Health Service is able to collect.

Senate Report 100–508, 100th Cong., 2nd Sess. 1988, 1988 U.S.C.C.A.N. 6183.

In 1996, Congress, based on evidence presented to it regarding the success of the IHCIA demonstration program, extended the program for two more years to allow time for the Department of Health and Human Services to make its report to Congress. The program was extended again in 1998, based upon a favorable report made to Congress by the Department.

DEMONSTRATION PROGRAM RESULTS

Four facilities were chosen to participate in the demonstration program: the Southeast Alaska Regional Health Consortium (SEARHC), Sitka, Alaska; the Bristol Bay Area Health Corporation, Dillingham, Alaska; the Choctaw Nation of Oklahoma, Durant, Oklahoma; and the Mississippi Band of Choctaw Indians, Philadelphia, Mississippi.

Under the terms of the demonstration program, the participants were authorized to make claims directly to the Fiscal Intermediary for reimbursement. To become a participant, the tribe's facility had

[1] See Department of Health and Human Services, Report to Congress on the tribal Demonstration Program on Direct Billing for Medicare, Medicaid and Other Third Party Payors, Appendix D, December 15, 1998.

to meet IHS requirements for operation of its own programs and the facility needed to be accredited by the Joint Commission on Accreditation of Healthcare Organizations.

All funds reimbursed were required to be used for specific purposes. The first priority for the funds received was to make improvements within the facility which would allow it to maintain compliance with the conditions and requirements applicable generally to all facilities under medicare and medicaid programs (to continue to be accredited). If funds remained after compliance was maintained, the excess was to be used only to improve the health resources available to the Indian tribe. All funds were to be expended in accordance with IHS regulations applicable to funds provided by the IHS under a contract entered into under the Indian Self-Determination Act (25 U.S.C. 450 et seq.).

The Medicare and Medicaid Direct Billing Demonstration Program was, by all accounts, a success. The Department of Health and Human Services, in a report delivered to Congress in December of 1998, stated that the "demonstration project has been a success as it has simplified, streamlined, and increased collections."

The Department reported that the direct billing process had positive effects for the four participating tribes. First, medicare and medicaid collections increased dramatically at all four facilities. The increase in collections for both medicaid and medicare combined ranged from 152% at the SEARHC facility to 364% at the Bristol Bay facility. Second, the increased collections were used by all four tribes to address compliance issues at their facilities. During the term of the demonstration project, all four facilities reported increases in their status and ratings with the accrediting body and three of the projects reported significant increases in their standing. SEARHC reported receiving the highest score possible. The SEARHC facility also received the highest ranking possible for the years 1996 and 1997. Third, three of the four participants also reported that they expended excess funds to improve the health resources available to the tribe. Most of these funds were used to improve facilities, to acquire additional medical equipment, and to hire additional staff. The Mississippi Band of Choctaw Indians reported that additional funds were used to open three new clinics, geared toward tuberculosis, diabetes and Women's Wellness. The Choctaw Nation of Oklahoma reported program expansions at three locations, the opening of a diabetes treatment center and the use of an improved information system. The remaining participants reported that the increased collections were used to hire new staff and implement projects that both improved their accreditation rating and improved the health resources offered by the tribe. Finally, all projects reported a large decrease in the amount of time between billing and collection. Each tribe reported saving at least two months time, and one tribe reported saving up to eight months time between billing and collection. This was largely due to increased, direct contact with the Fiscal Intermediary. The participants reported that the direct contact with the Fiscal Intermediary allowed them to "improve billings and collection practices, improve management of accounts receivable, reduce the time

between billing and collection, and improve management planning on use of collections."[2]

The Department of Health and Human Services recommended that the demonstration program be made permanent and that the program be open to an expanded number of participants. S. 406 creates a more efficient and effective means for the medicare and medicaid reimbursement to tribes. But more importantly, it is a recognition of the government to government relationship that exists between the federal government and Indian tribes, and furthers the policy of tribal self-determination by allowing tribes to best determine the allocation and use of funds received.

COMMITTEE ACTION

S. 406 was introduced on February 10, 1999, by Senator Frank Murkowski (R-AK). The bill was passed by the Senate on September 15, 1999, with amendments by unanimous consent. The bill was referred primarily to the Committee on Resources, and additionally to the Committee on Commerce and the Committee on Ways and Means. On April 5, 2000, the Committee met to consider the bill. No amendments were offered and the bill was then ordered favorably reported by voice vote to the House of Representatives.

SECTION BY SECTION ANALYSIS

SECTION 1. SHORT TITLE

This section provides the short title of bill, the Alaska Native and American Indian Direct Reimbursement Act of 1999.

SECTION 2. FINDINGS

This section describes the history and of benefits of the direct billing program.

SECTION 3. DIRECT BILLING OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS

Subsection (a) amends Section 405 of IHCIA (25 U.S.C. 1645) to provide for the permanent authorization and establishment of the direct billing program. Specifically, the amendments to Section 405 of IHCIA are as follows:

Subsection (a)(1) authorizes tribes to directly bill for payment to be made under the medicare program (Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)), state plans for medical assistance approved under Title XIX of the Social Security Act, and third party payors.

Subsection (a)(2) provides for direct billing from the medicaid program (section 1905(b) of the Social Security Act, 42 U.S.C. 1396(b)).

Subsection (b)(1) specifies that the funds reimbursed will first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and require-

[2] See Department of Health and Human Services, Report to Congress on the Tribal Demonstration Program on Direct Billing for Medicare, Medicaid and Other Third Party Payors, page 9, December 15, 1998.

ments applicable to facilities of such type under the medicare or medicaid programs.

Subsection (b)(2) states that all tribal hospitals and clinics participating in the program shall be subject to all auditing requirements applicable to programs administered directly by the IHS.

Subsection (b)(3) provides for Secretarial (of the Department of Health and Human Services) oversight of the program by requiring the submission of annual reports by participants of the program.

Subsection (b)(4) ensures that no payments will be made out of the special funds described in Section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) or section 402(a) of IHCIA.

Subsection (c)(1) establishes the eligibility requirements for participation in the program.

Subsection (c)(2) sets forth the required contents of the tribal application for participation in the program; the timeline for approval of the submitted applications; allows for the continued, uninterrupted participation of the demonstration program participants; and states the duration of the approved application.

Subsection (d)(1) gives the authority to the Secretary of the Department of Health and Human Services for the implementation of any administrative changes that may be necessary to facilitate direct billing and reimbursement.

Subsection (d)(2) sets out the reporting requirements for accounting information that a participant will have to submit to the Secretary, and provides for periodic changes in the required information.

Subsection (e) allows for a participant to withdraw from the program in the same manner that a tribe retrocedes a contracted program to the Secretary of Health and Human Services under authority of the Indian Self-Determination Act (25 U.S.C. 450 et seq.)

The remaining subsections provide for conforming amendments and an effective date of October 1, 2000.

COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

Regarding clause 2(b)(1) of rule X and clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee on Resources' oversight findings and recommendations are reflected in the body of this report.

CONSTITUTIONAL AUTHORITY STATEMENT

Article I, section 8 of the Constitution of the United States grants Congress the authority to enact this bill.

COMPLIANCE WITH HOUSE RULE XIII

1. Cost of Legislation. Clause 3(d)(2) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison by the Committee of the costs which would be incurred in carrying out this bill. However, clause 3(d)(3)(B) of that rule provides that this requirement does not apply when the Committee has included in its report a timely submitted cost estimate of the bill prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act of 1974.

2. Congressional Budget Act. As required by clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section

308(a) of the Congressional Budget Act of 1974, this bill does not contain any new budget authority, credit authority, or an increase or decrease in revenue or tax expenditures. According to the Congressional Budget Office, enactment of S. 406 would increase federal outlays by $8–9 million in each of fiscal years 2001 through 2005.

3. Government Reform Oversight Findings. Under clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee has received no report of oversight findings and recommendations from the Committee on Government Reform on this bill.

4. Congressional Budget Office Cost Estimate. Under clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 403 of the Congressional Budget Act of 1974, the Committee has received the following cost estimate for this bill from the Director of the Congressional Budget Office:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 1, 2000.

Hon. DON YOUNG,
Chairman, Committee on Resources,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 406, the Alaska Native and American Indian Direct Reimbursement Act of 1999.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts for federal costs and intergovernmental mandates are Eric Rollins and Leo Lex, respectively.

Sincerely,

BARRY B. ANDERSON
(For Dan L. Crippen, Director).

Enclosure.

S. 406—Alaska Native and American Indian Direct Reimbursement Act of 1999

Summary: S. 406 would extend indefinitely an Indian Health Service (IHS) demonstration project that allows four tribally operated IHS facilities to bill the Medicare and Medicaid programs directly, rather than submitting their claims through the IHS. The act also would allow all other tribally operated IHS facilities to bill Medicare and Medicaid directly. CBO estimates that S. 406 would raise federal outlays by $8 million to $9 million in each of fiscal years 2001 through 2005. (Federal Medicare outlays would be higher by about $2 million a year, and federal Medicaid outlays would be higher by about $6 million a year.) Because the act would affect direct spending, pay-as-you-go procedures would apply.

S. 406 contains no private-sector or intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). Participation in the direct billing program would improve the cash-flow of health facilities operated by tribal governments and increase their total Medicaid funding.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 406 is shown in the following table. The costs

of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	Outlays, by fiscal year, in millions of dollars—					
	2000	2001	2002	2003	2004	2005
CHANGES IN DIRECT SPENDING						
Medicare	0	3	2	2	2	2
Medicaid	0	6	6	5	5	6
Total	0	9	8	8	8	8

Note. Components may not sum to totals because of rounding.

Basis of Estimate: Under current law, four tribally operated Indian Health Service demonstration sites are authorized to bill the Medicare and Medicaid programs directly rather than submitting their claims through the IHS. The demonstration authority expires on September 30, 2000. S. 406 would allow all tribally operated IHS facilities to bill Medicare and Medicaid directly.

According to IHS, seven hospitals are tribally operated and would likely choose to bill Medicare and Medicaid directly. In 1999, Medicare and Medicaid collections totaled $56 million in these facilities. In addition, more than 150 health stations, health centers, and clinics would be eligible to bill directly under the legislation. CBO assumes that all of the hospitals would choose to bill directly over the next several years but that only a few of the largest of the other facilities would develop the infrastructure necessary to adopt direct billing. CBO further assumes that a few additional hospitals would become tribally operated and begin to bill directly.

Based on information from the IHS on the experiences in the demonstration sites, CBO expects that direct billing would increase Medicare and Medicaid payments for two reasons. First, the demonstration sites report a reduction in the amount of time between filing reimbursement claims and receiving payment. CBO therefore assumes that in the first year a facility participated in direct billing, it would receive one to two extra months worth of Medicare and Medicaid payments. The legislation would also accelerate federal spending for the four existing demonstration sites because under current law they are required to return to billing Medicare and Medicaid through IHS and will therefore experience a one- to two-month slow-down in Medicare and Medicaid collections. Of the $41 million in estimated Medicare and Medicaid costs over the 2001–2005 period, $10 million is attributable to the one-time acceleration of payments.

Second, demonstration sites also reported increased Medicare and Medicaid payments under direct billing because of improved claims processing. The sites reported that they were better able to track their claims and correct errors under direct billing than when they filed their claims through the IHS. Medicare and Medicaid payments have grown dramatically in both demonstration sites and nondemonstration IHS facilities in the 11 years since the demonstration was authorized. Much of the growth stems from higher Medicare and Medicaid reimbursement rates for IHS facilities, efforts by IHS to improve its Medicare and Medicaid collections, and general growth in medical costs and enrollment, rather than from direct billing. Nonetheless, based on the experience in the demonstration sites, CBO estimates that the improved claims proc-

essing procedures that would result from direct billing would increase Medicare and Medicaid payments by about 10 percent for the facilities that choose to undertake it.

In addition, direct billing may slightly reduce IHS administrative costs, which are subject to annual appropriation.

Pay-As-You-Go Considerations: The Balanced Budget and Emergency Deficit Control act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that are subject to pay-as-you-go procedures are shown in the following table. (S. 406 would not affect receipts.) For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By fiscal year, in millions of dollars—										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	9	8	8	8	8	9	9	10	10	11
Changes in receipts	Not applicable										

Estimated impact on State, local, and tribal governments: S. 406 contains no intergovernmental mandates as defined in UMRA. by allowing all tribally operated IHS facilities to directly bill the Department of Health and Human Services for Medicare and Medicaid services, the act would shorten the period of time for receiving reimbursements and improve processing procedures. CBO estimates that those facilities would receive a total of between $5 million and $7 million annually in additional Medicaid reimbursements. Since the federal medical assistance percentage is 100 percent for tribal health facilities, S. 406 would increase total funding and improve the cash-flow position of facilities that chose to participate in the direct billing program.

Estimated impact on the private sector: S. 406 contains no private-sector mandates as defined in UMRA.

Previous CBO estimate: On August 27, 1999, CBO estimated that S. 406, as ordered reported by the Senate Committee on Indian Affairs on August 4, 1999, would increase direct spending by $37 million over the 2000–2004 period. The language in the Senate version of S. 406 is substantively the same as that in the version that was ordered reported by the House Committee on Resources. CBO has updated its earlier estimate to include more recent data on Medicare and Medicaid collections by IHS facilities (which were lower than expected) and to show the legislation's effects in 2005.

Estimate prepared by: Federal costs: Eric Rollins; impact on State, local, and tribal governments: Leo Lex; impact on the private sector: Stuart Hagen.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

COMPLIANCE WITH PUBLIC LAW 104–4

This bill contains no unfunded mandates.

PREEMPTION OF STATE, LOCAL OR TRIBAL LAW

This bill is not intended to preempt any State, local or tribal law.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 405 OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

DEMONSTRATION PROGRAM FOR DIRECT BILLING OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS

SEC. 405. [(a) The Secretary shall establish a demonstration program under which Indian tribes, tribal organizations, and Alaska Native health organizations, which are contracting the entire operation of an entire hospital or clinic of the Service under the authority of the Indian Self-Determination Act, shall directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under title XVIII of the Social Security Act (medicare), under a State plan for medical assistance approved under title XIX of the Social Security Act (medicaid), or from any other third-party payor. The last sentence of section 1905(b) of the Social Security Act shall apply for purposes of the demonstration program.

[(b)(1) Each hospital or clinic participating in the demonstration program described in subsection (a) shall be reimbursed directly under the medicare and medicaid programs for services furnished, without regard to the provisions of section 1880(c) of the Social Security Act and sections sections 402(a) and 813(b)(2)(A) of this Act, but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used—

[(A) solely for improving the health resources deficiency level of the Indian tribe, and

[(B) in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the Indian Self-Determination Act.

[(2) The amounts paid to the hospitals and clinics participating in the demonstration program described in subsection (a) shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare and medicaid programs.

[(3) The Secretary shall monitor the performance of hospitals and clinics participating in the demonstration program described in subsection (a), and shall require such hospitals and clinics to submit reports on the program to the Secretary on a quarterly basis (or more frequently if the Secretary deems it to be necessary).

[(4) Notwithstanding section 1880(c) of the Social Security Act or section 402(a) of this Act, no payment may be made out of the spe-

cial fund described in section 1880(c) of the Social Security Act, or section 402(a) of this Act, for the benefit of any hospital or clinic participating in the demonstration program described in subsection (a) during the period of such participation.

[(c)(1) In order to be considered for participation in the demonstration program described in subsection (a), a hospital or clinic must submit an application to the Secretary which establishes to the satisfaction of the Secretary that—

[(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts the entire operation of the Service facility;

[(B) the facility is eligible to participate in the medicare and medicaid programs under sections 1880 and 1911 of the Social Security Act;

[(C) the facility meets any requirements which apply to programs operated directly by the Service; and

[(D) the facility is accredited by the Joint Commission on Accreditation of Hospitals, or has submitted a plan, which has been approved by the Secretary, for achieving such accreditation prior to October 1, 1990.

[(2) From among the qualified applicants, the Secretary shall, prior to October 1, 1989, select no more than 4 facilities to participate in the demonstration program described in subsection (a). The demonstration program described in subsection (a) shall begin by no later than October 1, 1991, and end on September 30, 1996.

[(d)(1) Upon the enactment of the Indian Health Care Amendments of 1988, the Secretary, acting through the Service, shall commence an examination of—

[(A) any administrative changes which may be necessary to allow direct billing and reimbursement under the demonstration program described in subsection (a), including any agreements with States which may be necessary to provide for such direct billing under the medicaid program; and

[(B) any changes which may be necessary to enable participants in such demonstration program to provide to the Service medical records information on patients served under such demonstration program which is consistent with the medical records information system of the Service.

[(2) Prior to the commencement of the demonstration program described in subsection (a), the Secretary shall implement all changes required as a result of the examinations conducted under paragraph (1).

[(3) Prior to October 1, 1990, the Secretary shall determine any accounting information which a participant in the demonstration program described in subsection (a) would be required to report.

[(f) The Secretary shall provide for the retrocession of any contract entered into between a participant in the demonstration program described in subsection (a) and the Service under the authority of the Indian Self-Determination Act. All cost accounting and billing authority shall be retroceded to the Secretary upon the Secretary's acceptance of a retroceded contract.]

(a) ESTABLISHMENT OF DIRECT BILLING PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a program under which Indian tribes, tribal organizations, and Alaska Native health organizations that contract or compact for the op-

eration of a hospital or clinic of the Service under the Indian Self-Determination and Education Assistance Act may elect to directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (in this section referred to as the "medicare program"), under a State plan for medical assistance approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (in this section referred to as the "medicaid program"), or from any other third party payor.

(2) APPLICATION OF 100 PERCENT FMAP.—The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) shall apply for purposes of reimbursement under the medicaid program for health care services directly billed under the program established under this section.

(b) DIRECT REIMBURSEMENT.—

(1) USE OF FUNDS.—Each hospital or clinic participating in the program described in subsection (a) of this section shall be reimbursed directly under the medicare and medicaid programs for services furnished, without regard to the provisions of section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) and sections 402(a) and 813(b)(2)(A), but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid programs. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions shall be used—

(A) solely for improving the health resources deficiency level of the Indian tribe; and

(B) in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the Indian Self-Determination Act (25 U.S.C. 450f et seq.).

(2) AUDITS.—The amounts paid to the hospitals and clinics participating in the program established under this section shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare and medicaid programs.

(3) SECRETARIAL OVERSIGHT.—The Secretary shall monitor the performance of hospitals and clinics participating in the program established under this section, and shall require such hospitals and clinics to submit reports on the program to the Secretary on an annual basis.

(4) NO PAYMENTS FROM SPECIAL FUNDS.—Notwithstanding section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) or section 402(a), no payment may be made out of the special funds described in such sections for the benefit of any hospital or clinic during the period that the hospital or clinic participates in the program established under this section.

(c) REQUIREMENTS FOR PARTICIPATION.—

(1) APPLICATION.—Except as provided in paragraph (2)(B), in order to be eligible for participation in the program established under this section, an Indian tribe, tribal organization, or Alas-

ka Native health organization shall submit an application to the Secretary that establishes to the satisfaction of the Secretary that—

(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts or compacts for the operation of a facility of the Service;

(B) the facility is eligible to participate in the medicare or medicaid programs under section 1880 or 1911 of the Social Security Act (42 U.S.C. 1395qq; 1396j);

(C) the facility meets the requirements that apply to programs operated directly by the Service; and

(D) the facility—

(i) is accredited by an accrediting body as eligible for reimbursement under the medicare or medicaid programs; or

(ii) has submitted a plan, which has been approved by the Secretary, for achieving such accreditation.

(2) APPROVAL.—

(A) IN GENERAL.—The Secretary shall review and approve a qualified application not later than 90 days after the date the application is submitted to the Secretary unless the Secretary determines that any of the criteria set forth in paragraph (1) are not met.

(B) GRANDFATHER OF DEMONSTRATION PROGRAM PARTICIPANTS.—Any participant in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 1999 shall be deemed approved for participation in the program established under this section and shall not be required to submit an application in order to participate in the program.

(C) DURATION.—An approval by the Secretary of a qualified application under subparagraph (A), or a deemed approval of a demonstration program under subparagraph (B), shall continue in effect as long as the approved applicant or the deemed approved demonstration program meets the requirements of this section.

(d) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

(1) IN GENERAL.—The Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, shall examine on an ongoing basis and implement—

(A) any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this section, including any agreements with States that may be necessary to provide for direct billing under the medicaid program; and

(B) any changes that may be necessary to enable participants in the program established under this section to provide to the Service medical records information on patients served under the program that is consistent with the medical records information system of the Service.

(2) ACCOUNTING INFORMATION.—The accounting information that a participant in the program established under this section shall be required to report shall be the same as the information

required to be reported by participants in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 1999. The Secretary may from time to time, after consultation with the program participants, change the accounting information submission requirements.

(e) WITHDRAWAL FROM PROGRAM.—A participant in the program established under this section may withdraw from participation in the same manner and under the same conditions that a tribe or tribal organization may retrocede a contracted program to the Secretary under authority of the Indian Self-Determination Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this section shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

SOCIAL SECURITY ACT

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART D—MISCELLANEOUS PROVISIONS

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INDIAN HEALTH SERVICE FACILITIES

SEC. 1880. (a) * * *

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(e) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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INDIAN HEALTH SERVICE FACILITIES

SEC. 1911. (a) * * *

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(d) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations

and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).

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APPENDIX

HOUSE OF REPRESENTATIVES,
COMMITTEE ON RESOURCES,
Washington, DC, June 13, 2000.

Hon. TOM BLILEY,
Chairman, Committee on Commerce,
Rayburn HOB, Washington, DC.

DEAR MR. CHAIRMAN: On April 5, 2000, the Committee on Resources ordered reported without amendment S. 406, the Alaska Native and American Indian Direct Reimbursement Act of 1999. The Senate passed the bill by unanimous consent on September 15, 1999. The purpose of the bill is to make permanent a very successful demonstration program under the Indian Health Care Improvement Act Amendments (Public Law 100–713) that allows tribes to directly bill for Medicare and Medicaid reimbursements. S. 406 was primarily referred to the Committee on Resources and additionally to the Committee on Commerce and the Committee on Ways and Means.

Because of the limited numbers of days remaining in the 106th Congress, I seek your help in allowing S. 406 to be scheduled for consideration by the House of Representatives without further action by the Committee on Commerce. I would propose to pass the Senate bill without amendment and forward it to the President for signature.

Of course, by allowing this to occur, the Committee on Commerce does not waive its jurisdiction over S. 406 or any other similar matter, and this action should not be seen as precedent for any other Senate bills which affect the Committee on Commerce's jurisdiction. I can place this letter and your response in the Committee on Resources' bill report or to insert our exchange of letters in the Congressional Record during consideration of the bill on the Floor to document this agreement.

I appreciate your continued cooperation and that of your staff in moving this important Native American bill, as well as several others this session of Congress.

Sincerely,

DON YOUNG, *Chairman.*

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
Washington, DC, June 13, 2000.

Hon. DON YOUNG,
Chairman, Committee on Resources, Longworth House Office Building, Washington, DC.

DEAR DON: I am writing with regard to S. 406, the Alaska Native and American Indian Direct Reimbursement Act of 1999. As you know, Rule X of the Rules of the House of Representatives grants the Committee on Commerce jurisdiction over public health and quarantine. Accordingly, legislation addressing the interaction of the Indian Health Service with the Medicare and Medicaid programs fall within the Committee's jurisdiction.

Section 3 of S. 406, as ordered reported by the Committee on Resources, makes permanent a demonstration project permitting Indian Health Service (IHS) facilities to bill the Medicare and Medicaid programs directly, rather than requiring all such billing to be routed through IHS.

Because of the importance of this legislation, I recognize your desire to bring it before the House in an expeditious manner, and I will not exercise the Committee's right to exercise its referral. By agreeing to waive its consideration of the bill, however, the Committee on Commerce does not waive its jurisdiction over S. 406. In addition, the Commerce Committee reserves its authority to seek conferees on any provisions of the bill that are within its jurisdiction during any House-Senate conference that may be convened on this legislation, should it be amended. I ask for your commitment to support any request by the Commerce Committee for conferees on S. 406 or similar legislation.

I request that you include this letter and your response in your committee report on the bill and as part of the Record during consideration of the legislation on the House floor.

Thank you for your attention to these matters.

Sincerely,

TOM BLILEY, *Chairman.*

HOUSE OF REPRESENTATIVES,
COMMITTEE ON RESOURCES,
Washington, DC, July 28, 2000.

Hon. BILL ARCHER,
Chairman, Committee on Ways and Means,
Longworth HOB, Washington, DC.

DEAR MR. CHAIRMAN: On April 5, 2000, the Committee on Resources ordered reported without amendment S. 406, the Alaska native and American Indian Direct Reimbursement Act of 1999. The Senate passed the bill by unanimous consent on September 15, 1999. The purpose of the bill is to make permanent a very successful demonstration program under the Indian Health Care Improvement Act Amendments that allows tribes to directly bill for Medicare and Medicaid reimbursements. S. 406 was primarily referred to the Committee on Resources and additionally to the Committees on Commerce and Ways and Means.

Because of the limited numbers of days remaining in the 106th Congress, I seek your help in allowing S. 406 to be scheduled for consideration by the House of Representatives without further action by the Committee on Ways and Means. As you outlined in your letter, I propose to pass the Senate bill without amendment under suspension of the bills and forward it to the President for signature. Chairman Bill Bliley of the Committee on Commerce has agreed to this procedure.

Of course, by allowing this to occur, the Committee on Ways and Means does not waive its jurisdiction over S. 406 or any other similar matter, and this action should not be seen as precedent for any other Senate bills which affect your Committee's jurisdiction. I can place this letter and your response in the Committee on Resources' bill report to document this agreement.

I appreciate your continued cooperation and that of your staff in moving this important Native American bill.

Sincerely,

DON YOUNG, *Chairman.*

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, July 28, 2000.

Hon. DON YOUNG,
Chairman, Committee on Resources, Longworth House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: I am writing in regard to S. 406, the Alaska Native and American Indian Direct Reimbursement Act of 1999, as ordered reported by the Committee on Resources.

The bill would make permanent a demonstration project permitting Indian Health Service (IHS) facilities to bill the Medicare program directly, rather than requiring all billing to be routed through the IHS. As you know, legislation addressing the interaction of the Indian Health Service with the Medicare program would fall within the jurisdiction of the Committee on Ways and Means.

Normally, the committee would meet to consider such legislation. However, in order to expedite consideration of S. 406, I will not object to this legislation, and, for this reason, it will not be necessary for the committee on Ways and means to meet to consider the bill.

However, this is being done with the understanding that you will bring the bill to the floor under suspension of the rules for final action prior to transmission of the bill to the President, and that you have agreed to accept no additional changes on these or any other matters of concern to this Committee during further consideration of this legislation. This action is also being done with the understanding that it will not prejudice the jurisdictional prerogatives of the Committee on Ways and Means on these provisions or any other similar legislation and will not be considered as precedent for consideration of matters of jurisdictional interest to my Committee in the future.

Finally, I would ask that you include a copy of our exchange of letters on this matter in your Committee Report on the legislation.

Thank you for your assistance and cooperation in this matter. With warm personal regards,

Sincerely,

BILL ARCHER, *Chairman.*

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