

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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Submitted via: www.regulations.gov

May 20, 2016

Betty Gould, Regulations Officer
Indian Health Service, Office of Management Services
5600 Fishers Lane, Mailstop 09E70
Rockville, Maryland 20857

RE: Comments on Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated With Non-Hospital-Based Care Final Rule (RIN 0917-AA12)

Dear Ms. Gould,

I write on behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) to comment on the final rule with comment period titled "Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital-Based Care" and published in the Federal Register on March 21, 2016 (Final Rule). The Final Rule implements a methodology and payment rates for IHS Purchased/Referred Care (PRC), formerly known as the Contract Health Services (CHS), to apply Medicare payment methodologies to all physician and other health care professional services and nonhospital-based services. Specifically, it will allow the health programs operated by IHS, Tribes and Tribal organizations, and urban Indian organizations (I/T/Us) to negotiate or pay non-I/T/U providers based on the applicable Medicare fee schedule, prospective payment system, Medicare rate, or in the event of a Medicare waiver, the payment amount calculated in accordance with such waiver; the amount negotiated by a repricing agent, if applicable; or the most favored customer (MFC) rate of the provider or supplier.

We appreciate the consideration given to the prior set of comments submitted by the TSGAC¹ on February 4, 2015, and we request similar consideration to the comments made here.

The TSGAC has two major concerns about the Final Rule. First, the definitions section at § 136.202 does not make an adequate distinction between a "referral for services" and an "authorization for payment" by the IHS. Second, the applicability provision at § 136.201 establishes

¹ See "Comments on IHS Proposed Rule Entitled 'Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital-Based Care,' 79 Fed. Reg. 72160 (Dec. 5, 2014)," filed by TSGAC on February 4, 2015, at <https://www.regulations.gov/#!documentDetail:D=IHS-2015-0001-0026>.

a method by which Tribes can “opt-in” to the requirements of the Final Rule; this method, however, is overly complicated and inappropriately requires Tribes to obtain permission from IHS.

We offer additional thoughts about these issues below. In addition, we provide discussion on the IHS responses to previous recommendations that we submitted in response to the proposed version of the Final Rule.

Discussion

Issue 1. Definition of Referral

In the Final Rule, the IHS added a definition section at § 136.202 to define important terms, including “referral.” The Final Rule contains the following definition:

“Referral means an authorization for medical care by the appropriate ordering official in accordance with 42 CFR part 136 subpart C.”

42 CFR part 136 subpart C makes reference to payment for medical care and services obtained from non-Service providers or in non-Service facilities. This subpart does not make reference to a “referral for services,” but rather to a purchase order, which constitutes an “authorization for payment.” As drafted, the Final Rule does not make clear the distinction between “referral for services” and “authorization for payment.”

Recommendation: The IHS should define both the terms “referral for services” and “authorization for payment,” clarifying that a referral for services occurs without regard to whether IHS makes a commitment for payment. This change would provide a needed distinction between these terms and make the Final Rule consistent with other regulations. For example, the Affordable Care Act (ACA) uses the concept of a CHS/PRC referral for individuals enrolled in limited cost-sharing variation plans. The ACA referral advises the provider that they may not charge the patient any co-payments. The referral does not authorize payment for services, but rather indicates that the individual receiving the referral has a relationship with an I/T/U. The CHS/PRC program can issue either a referral for services or an authorization for payment. A CHS/PRC authorization tells the non-I/T/U provider that CHS/PRC program will pay for the services authorized. The use of the term referral under the current definition will cause confusion for patients, providers, and may result in cost-sharing being charged when it should not have been. This is very important for those Tribes that sponsor insurance for their users and make referrals to exchange plans. Again, we request that both terms (“referral” and “authorization”) be defined, but be defined in a manner that distinguishes between the two activities.

Issue 2. Opt-In Method

The IHS at §136.201 added an applicability provision to specify that the Final Rule applies to IHS-operated CHS/PRC programs, urban Indian health programs, and Tribally operated programs, but only to the extent that the Tribally operated programs opt-in to the requirements of the rule.

During several meetings, IHS has indicated that the opt-in decision will occur through a modification to the existing annual funding agreement of a Tribe. This opt-in method requires undergoing an overly complicated process, as well as obtaining IHS agreement or concurrence, as a modification to an annual funding agreement requires approval of both the Tribe and the IHS. In addition, under this opt-in method, it appears that IHS is asking Tribes to assume agency requirements for eligibility for CHS/PRC, even though Self-Governance Tribes have the authority to redesign their requirements to meet the needs of their Tribal communities.

Recommendation: The IHS should make the opt-in method as simple as a Tribe sending a letter to the IHS to notify the agency of its decision to opt-in to the requirements of the Final Rule. The opt-in method should necessitate only a unilateral decision by a Tribe and should not require IHS agreement or concurrence.

Recommendation: Because of the complication and timing to modify an annual funding agreement, the rule should include a notification process to opt-out of the rule if a CHS/PRC program has included an opt-in proviso in its annual funding agreement. If a Tribe finds that this rule is not working as it should and restricts access to specialty care, than the Tribe should be able to notify IHS that it would like to cancel its opt-in provision in the annual funding agreement without going through an onerous process and timely delay.

Issue 3. Prior Recommendations

On February 4, 2015, the TSGAC filed comments on the proposed version of the Final Rule. A discussion of our prior recommendations, as well as the responses offered by the IHS in the Final Rule, appears below.

- i. Recommendation—Tribal Consultation: The proposed rule would have significant Tribal implications and substantial direct effects on one or more Tribes; the IHS should engage in Tribal consultation before finalizing the rule.

Response: According to the IHS, "IHS consulted with Tribes, during listening sessions and other meetings, on whether Tribes thought IHS should pursue applying PRC rates for nonhospital-based services. It has been noted that, while these interactions indicated that regulations may have been a good idea, the level of discussion did not get into the complexities of developing a regulation and how such regulations would impact Tribes given the variation in access to specialty care and the number of hospitals across the Indian health system. IHS recognizes that specific provisions of the rule were not developed in consultation with Tribes. In the development of this final rule, however, IHS has collaborated significantly with the Director's PRC Workgroup. The PRC workgroup is composed of technical experts who have a deep understanding of the complexities of administering PRC programs. The rule has been revised to provide the flexibility many Tribal stakeholders have requested, and as finalized, will not apply to any Tribally-operated PRC program until it elects to opt-in in accordance with § 136.201. IHS recognizes that

these steps may not relieve all concerns regarding Tribal consultation. Accordingly, IHS is also publishing this final rule with a comment period in which to receive additional feedback from stakeholders, to determine whether any revisions should be made to the rule.” [81 FR 14980]

The TSGAC appreciates that the IHS is engaging in Tribal consultation and encourages the agency to give full consideration to the recommendations in this letter, as it did with the comments submitted in response to the proposed version of the Final Rule.

- ii. Recommendation—Treatment of Professional Services Under Existing Medicare-Like Rate Regulations: The titles for Subpart I and Section 136.201 erroneously suggest that current Medicare-Like Rate regulations do not apply to care provided by physicians and other health care professionals. The IHS should clarify that the rule applies to all non-hospital providers (including non-hospital-based physicians and other health care professionals).

Response: The IHS added at § 136.201 an applicability provision to specify that the rule applies to IHS-operated PRC programs, urban Indian health programs, and Tribally operated programs. In addition, the IHS added at § 136.202 a definition section to define certain terms used in the rule.

In regard to application of the Final Rule to physicians and other health care professionals, the IHS stated, “The PRC rate regulations at part 136 subpart D apply to hospitals and critical access hospitals pursuant to section 1866(a)(1)(U) of the Social Security Act ... The agreement executed by hospitals and critical access hospitals under section 1866 does not govern payment for professional services under Medicare, even for services provided by physician employees of a hospital or for ‘billing under arrangements,’ and, accordingly, does not generally govern the acceptance of payment for services under Medicare Part B. To eliminate any confusion, the terms Supplier and Provider have been defined in § 136.201 to only include entities that are not subject to Part 136 Subpart D. Supplier means a physician or other practitioner, a facility, or other entity (other than a provider) not already governed by or subject to 42 CFR part 136 subpart D that furnishes items or services under this new Subpart. Provider, as used in this subpart only, means a provider of services not governed by or subject to 42 CFR part 136 subpart D and may include a skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program.” [81 FR 14979-80]

We concur with the clarification provided by the IHS in the preamble to the Final Rule.

- iii. Recommendation—Section 136.201(a)(1)(3): Section 136.201 states that I/T/Us can pay only the lowest of either (1) the Medicare-Like Rate; (2) a rate negotiated by the I/T/U or its repricing agent; or (3) the amount the provider “bills the general public for the same service,” but (3) seems vague and might result in misinterpretation; IHS should change this provision

to the amount the provider “accepts as payment for the same service from nongovernmental entities, including insurance providers.”

Response: The IHS stated, “IHS agrees with the commenter that the proposed language may be open to more than one interpretation. To avoid multiple interpretations and to align this subsection with others changes made to § 136.203, the reference to “bills the general public” has been deleted and provisions have been inserted providing for payment not to exceed the provider or supplier’s MFC rate, as evidenced by commercial price lists or paid invoices and other related pricing and discount data to ensure that the I/T/U is receiving a fair and reasonable pricing arrangement. Additionally, in the event that a Medicare rate does not exist for an authorized item or service, and no other payment methodology provided by the rule is applicable, IHS has included a provision in 136.203(a)(3) that authorizes payment at 65% of authorized charges.” [81 FR 14979]

The TSGAC concurs with this change.

- iv. Recommendation—Need for Exceptions in New Section 136.201(b): Section 136.201(a) cites Medicare-Like Rates as the highest rates the IHS could pay, and this lack of discretion renders this provision unworkable in many areas in Indian country; the IHS should allow I/T/Us the discretion and flexibility to deal with unique circumstances that might necessitate negotiating a rate different from, or even higher than, the Medicare-Like Rate by adding the following sections to the rule:

- a. Section 136.201(b)(1): This section, which would apply to Tribes and Tribal organizations that have negotiated agreements with the IHS under the Indian Self-Determination and Education Act (ISDEAA) and urban Indian organizations, would make clear that they have the right to choose not to apply the rule; and

Response: The IHS noted, “IHS agrees with Tribal stakeholders that Tribal health programs should have the option to administer PRC programs outside of the rule. Rather than memorialize this option as an opt-out clause, IHS is finalizing the recommendation as an opt-in provision in section 136.201. The opt-in provision is intended to be consistent with 25 U.S.C. 458aaa-16(e), which provides, with certain exceptions, that Tribes are not subject to rules adopted by the IHS unless they are expressly agreed to by the Tribe in their compact, contract, or funding agreement with IHS. Although 25 U.S.C. 458aaa-16(e) only expressly applies to Tribes compacted under Title V of the ISDEAA, IHS is extending opt-in flexibility to Tribes contracted under Title I of the ISDEAA too.” [81 FR 14979]

We appreciated and agree with the clarification provided by the IHS. But, please see Issue 2 above for a discussion of our concerns about the requirement placed on Tribes to make a modification to the annual funding agreement in order to effectuate a Tribe’s decision to opt-in to the application of the requirements of the final rule.

- b. Section 136.201(b)(2): This section would allow I/T/Us, when necessary, to negotiate a rate with providers higher than the rate provided for in section 136.201(a), capping the rate at no more than what the provider charges non-governmental entities, including insurance providers, for the same service.

Response: IHS stated, "IHS agrees with commenters that more flexibility must be built into the rule. IHS also agrees with Tribal stakeholders that Tribes should be provided more flexibility to negotiate rates that exceed Medicare rates and agrees that controls should be put into place to ensure that negotiated rates remain fair and reasonable. Section 136.203 provides that, if a specific amount has been negotiated with a specific provider or supplier or its agent by the I/T/U, the I/T/U will pay that amount, provided such amount is equal to or better than the provider or supplier's MFC rate, as evidenced by commercial price lists or paid invoices and other related pricing and discount data, to ensure the I/T/U is receiving a fair and reasonable pricing arrangement. Further, the MFC rate does not apply if the I/T/U determines the prices offered to the I/T/U are fair and reasonable and the purchase of the service is otherwise in the best interest of the I/T/U. It will be incumbent on the provider of services to provide the necessary documentation to ensure the rates charged are fair and reasonable." [81 FR 14978-9]

The TSGAC concurs with this change.

Conclusion

Thank you for the opportunity to provide these comments on the Final Rule. The TSGAC believes that the Final Rule, with some modifications, will allow Tribally operated programs to improve their efficiency in the payment for services to non-I/T/U providers and facilities, enabling them to provide more health care services to Tribal communities. The TSGAC remains willing to assist the IHS in this endeavor in any way possible. If you have any questions or wish to discuss these comments further, please contact me at (860) 862-6192 or via email at lmalerba@moheganmail.com.

Sincerely,

Marilynn "Lynn" Malerba
Chief, The Mohegan Tribe of Connecticut
Chairwoman, Tribal Self-Governance Advisory Committee

cc: P. Benjamin Smith, Director, Office of Tribal Self-Governance, Indian Health Service
Tribal Self-Governance Advisory Committee Members