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Submitted via
www.regulations.gov

May 18, 2016

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

Re: Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated With Non-Hospital-Based Care

Dear Ms. Gould,

The United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) is pleased to provide the Indian Health Service (IHS) with the following comments on the final rule regarding "Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital-Based Care." We are very pleased to see that the IHS incorporated the recommendations made by USET SPF and Tribal Nations regarding flexibility in the application of the new payment methodologies. USET SPF believes that the consultation process resulted in a quality and balanced final rule. The following comments offer support for the inclusion of Tribal Nation recommendations, identify other provisions of the final rule that need additional clarification or amendments, and a request for consultation surrounding the payer of last resort.

USET SPF is a non-profit, inter-tribal organization representing 26 federally recognized Tribal Nations from Texas across to Florida and up to Maine[1]. Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service (IHS), which contains 36 IHS and Tribal health care facilities. Our citizens receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities operated under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

Support for the Inclusion of Tribal Nation Recommendations in the Final Rule

On February 4, 2015, USET SPF offered recommendations in response to the December 5, 2014 Notice of Public Rule Making (NPRM) entitled, "Payment for Physician and Other Health Care Professional Services Purchased by

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[1] USET SPF member Tribes include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

Indian Health Programs and Medical Charges Associated with Non-Hospital Based Care." In this comment letter, USET SPF demonstrated the critical need for Medicare-Like Rates (MLR) for non-hospital services in an effort to extend the resources of the chronically underfunded Purchased/Referred Care (PRC) account and ensure federal dollars are expended in a more efficient manner. As noted in a Government Accountability Office (GAO) report, implementing MLR for non-hospital services would extend the resources of the PRC program by an estimated $31.7 million annually. Additionally, we sought parity with other federal agencies, such as the Department of Veterans Affairs (VA) and the Department of Defense (DOD), which already impose a Medicare-equivalent rate for non-hospital services. Although we have on-going concerns about provider participation and patient access due to the lack of an enforcement mechanism, we believe this rule is a good first step in the effort to increase access to primary and specialty care through the PRC program.

In our previous comment letter, we noted several areas where IHS should amend the rule to provide additional flexibility for self-governing Tribal Nations that operate health programs through ISDEAA agreements. USET SPF supported an "opt out" provision to ensure that Tribal Nations could choose whether to implement the rule. We were encouraged to see that IHS acknowledged this request by incorporating an "opt in" provision for Title I and Title V Tribal Nations. USET SPF also suggested that, when necessary, Tribal Nations be able to negotiate rates with a provider that are higher than the MLR, but no higher than what the provider accepts from other non-governmental payers for the same service. We were happy to see similar language included in the final rule, allowing Tribal Nations to negotiate higher, but capped at a rate "equal to or better than" what the provider accepts from its Most Favored Customer.

USET SPF also requested that IHS clarify language to ensure that the rule extended MLR payment methodologies to all services provided in non-hospital settings, including health care professional services. We were pleased that the final rule defines eligible services rendered by "Providers and Suppliers' to include all services (including health professional services) not currently governed by the existing hospital-based MLR law. Similarly, we requested clarification on NPRM language, which in the absence of a negotiated rate, capped payment at the amount a provider "bills the general public for the same service." The final rule provides an extensive clarification on the payment options authorized by IHS when a Medicare rate does not exist for an authorized item or service.

Finally, we support IHS' efforts to offer PRC provider outreach and training for IHS and Tribally-operated facility business office staff. This will help reduce the risk of providers refusing to see American Indian and Alaska Native patients and assist Tribal Nations in the renegotiation of rates and provider agreements. Supporting the implementation of this rule with outreach and training opportunities is critical to its efficacy. USET SPF looks forward to an on-going dialogue and partnership with IHS in this effort.

<u>Request for a Report on the Implementation of the Final Rule</u>

In order to identify the success or failure of this regulatory effort, USET SPF reiterates our suggestion for IHS to engage in monitoring and evaluation of the rule's implementation. Without a legal enforcement mechanism, like the condition of participation in Medicare which exists for the Hospital MLR law, Tribal Nations are concerned that the rule could adversely impact patient access to care. Gathering data on patient access once the regulation is fully implemented will be imperative in determining its effectiveness and in galvanizing necessary legislative effort to codify and enforce the rule. We are hopeful that IHS can find additional resources through its various quality initiatives to ensure that the rule is, in fact, improving patient access to care and not causing unintentional harm.

<u>Definition of "Referral" in Final Rule</u>

USET SPF is apprehensive regarding the language used to define "referrals" in the definitions section of the final rule. In the rule, "referral" is defined as "an authorization for medical care by the appropriate ordering official in

accordance with 42 CFR part 136 subpart C." We are concerned this language inappropriately assumes a PRC program's obligation to authorize payment whenever a referral is offered by a provider. Tribal health programs routinely offer referrals for needed medical services, without the authorization of payment for those services. The authorization of payment requires a purchase order from PRC departments, in addition to a medical referral obtained by a provider. It is an unfortunate reality that many medically-necessary services must be denied by PRC departments when they do not meet the appropriate IHS "medical priority" criteria or when financial resources have been completely exhausted for the year. Additionally, Tribally-operated health programs are the payer of last resort and will not pay in instances where patients have access to alternate resources. We encourage IHS to modify the definition of "referral" in the final rule to better reflect the distinction between a referral for medical services and an authorization of payment from a PRC department.

<u>Clarification on Payer of Last Resort</u>

As noted throughout this letter, the resources available to Tribal Nations to operate their Purchased/Referred Care programs is inadequate. The resulting delays and denials of patient care lead to more severe and costly health conditions and increase health disparities. One of the ways that Tribal Nations fill these critical gaps in funding is by supplementing IHS dollars and self-funding programs with Tribally-generated resources. Tribal Nations will supplement in a variety of ways, including with grants to the health program or through Tribal Self-insurance. In many cases, this allows Tribal health programs to fund all medically-necessary services, rather than ration care based on the IHS PRC priority system. By providing adequate levels of care, Tribal Nations are able to avoid the costly complications associated with a patient's worsened health status, and are better equipped to support community health.

USET SPF is very discouraged to learn that Tribal Health programs that supplement their IHS funding may be prevented from fully implementing the MLR regulation. Recently, we learned that the federal government, in court litigation, is arguing that Section 2901(b) of the Affordable Care Act (ACA) invalidated longstanding IHS policy exempting Tribal self-insured health plans and other Tribal self-funding from the payer of last resort rule. This argument is contained in a Memorandum supporting the Government's Motion for Summary Judgment filed on March 15, 2016 in the U.S. District Court for the District of Columbia in *Redding Rancheria v. Sylvia Burwell*, Civ. No. 14-2035 (RMC).

It has been six years since enactment of the ACA in 2010. This appears to be a new legal argument devised by IHS lawyers for litigation purposes. The IHS has not formally rescinded its longstanding policy exempting Tribal self-insured plans and self-funding from the payer of last resort rule; nor has IHS invoked this new interpretation as a reason to exempt self-funding Tribal Nations from implementing the final rule. Further, Tribal Nations have not been consulted concerning this new interpretation. In fact, the Government's Memorandum filed in the *Redding Rancheria* case argues that this new interpretation of Section 2901(b) applies both to the Catastrophic Health Emergency Fund and to PRC programs operated by Tribal Nations under ISDEAA.

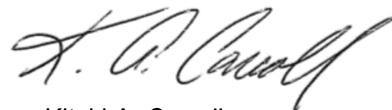
This novel interpretation is fundamentally inconsistent with both the plain language and intent of Section 2901(b) of the ACA, 25 U.S.C. 1623(b). It does not by its terms exclude Tribal self-insured or self-funded health programs from the list of programs covered. Nor was that its intent, which was instead to codify in statute longstanding IHS regulations and policies that ensured all Tribal health programs, including self-insured plans and self-funded programs were covered by the payer of last resort rule. The IHS' new litigation position is completely at odds with longstanding agency practice and the intent of Tribal advocates who urged the Congress to enact Section 2901(b) of the ACA. We urge additional consultation on this issue.

Provide an alternative mechanism for Tribal Nations to "Opt In" to Rule
Although we appreciate the opportunity for Tribal Nations to "opt in" to the rule, we believe there should be additional flexibility on how a Tribal Nation decides to declare their adoption of the MLR. During the April 21st "All Tribes" call regarding the final rule, we learned that Tribal Nations will have to make amendments to their ISDEAA funding agreements in order to implement the regulation. By requiring ISDEAA amendments, Tribal Nations will be forced to seek IHS approval in the adoption of MLR. USET SPF asserts that implementation of the rule must be a unilateral decision made by self-governing Tribal Nations. USET SPF requests that IHS provide additional methods, such as a "Letter of Intent," for Tribal Nations to express their desire to participate in the rule.

Conclusion
USET SPF appreciates the opportunity to comment on the IHS final rule implementing Medicare-Like Rates for non-hospital-based care. We remain optimistic that the rule will allow Tribal Nations to increase access to needed health services for their patients. We look forward to on-going consultation and partnership in the implementation of this final rule.

Should you have any questions or require additional information, please do not hesitate to contact Ms. Liz Malerba, USET Director of Policy and Legislative Affairs, at (202) 624-3550 or by e-mail at lmalerba@usetinc.org.

Sincerely,



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