United South and Eastern Tribes, Inc.

Nashville, TN Office:
711 Stewarts Ferry Pike, Suite 100
Nashville, TN 37214
Phone: (615) 872-7900
Fax: (615) 872-7417

Washington, DC Office:
400 North Capitol Street, Suite 585
Washington, D.C., 20001
Phone: (202) 624-3550
Fax: (202) 393-5218

Submitted via *http://regulations.gov*

February 4, 2015

Ms. Betty Gould,
Regulations Officer,
Indian Health Service,
801 Thompson Avenue,
TMP STE 450,
Rockville, Maryland 20852

Mr. Carl Harper, Director
Office of Resource Access and Partnerships,
Indian Health Service,
801 Thompson Avenue,
Rockville, Maryland 20852

Re: 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)

Dear Ms. Gould and Mr. Harper,

The United South and Eastern Tribes, Inc. (USET) is pleased to provide the Indian Health Service (IHS) with the following comments in response to the agency's December 5, 2014 Proposed Rule to expand the Medicare-Like Rate entitled "Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Program and Medical Charges Associated with Non-Hospital-Based Care," 79 Fed. Reg. 72160.

USET is a non-profit, inter-tribal organization representing 26 federally recognized Indian Tribes from Texas across to Florida and up to Maine.[1] Both individually, as well as collectively through USET, our member Tribes work to improve health care services for American Indians. Our member Tribes operate in the Nashville Area of the IHS, which contains 36 IHS and Tribal health care facilities. Tribal members may receive health care services

[1] USET member Tribes include: Alabama-Coushatta Tribe of Texas, Aroostook Band of Micmac Indians of Maine, Catawba Indian Nation of South Carolina, Cayuga Nation of New York, Chitimacha Tribe of Louisiana, Coushatta Tribe of Louisiana, Eastern Band of Cherokee Indians of North Carolina, Houlton Band of Maliseet Indians of Maine, Jena Band of Choctaw Indians of Louisiana, Mashantucket Pequot Indian Tribe of Connecticut, Mashpee Wampanoag Tribe of Massachusetts, Miccosukee Tribe of Florida, Mississippi Band of Choctaw Indians, Mohegan Tribe of Connecticut, Narragansett Indian Tribe of Rhode Island, Oneida Nation of New York, Passamaquoddy Tribe at Indian Township of Maine, Passamaquoddy Tribe at Pleasant Point of Maine, Penobscot Indian Nation of Maine, Poarch Band of Creek Indians of Alabama, Saint Regis Mohawk Tribe of New York, Seminole Tribe of Florida, Seneca Nation of New York, Shinnecock Indian Nation of New York, Tunica-Biloxi Tribe of Louisiana, and the Wampanoag Tribe of Gay Head (Aquinnah) of Massachusetts.

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.

USET strongly supports expanding Medicare-Like Rates beyond hospital-based providers, and believes that the Proposed Rule is a good step toward achieving that goal. However, as drafted the Proposed Rule does not provide the flexibility that is necessary to ensure continued access to care for American Indians and Alaska Natives (AI/ANs) through the Purchased/Referred Care (PRC) programs. Without a mechanism to ensure such flexibility, the Proposed Rule could operate to deny many AI/ANs access to critically important and life-saving services. We have proposed revisions to the Proposed Rule in Redline Format (Attached) that provide the Rule the flexibility it needs to ensure continued access to care while still lowering costs. As discussed below, we believe the Proposed Rule cannot work without these revisions. If IHS cannot incorporate the redline revisions, specifically the proposed exemption section, into the Final Rule, then we insist that IHS work with Tribes to come to an agreement. In that same vein, should the IHS accept these critical revisions, we recommend that the IHS promulgate a Final Rule rather than an Interim Final Rule, so that PRC programs are able to implement this necessary change in a timely manner.

Below are our general comments on the Proposed Rule followed by an explanation of our proposed revisions.

I. General Comments on the Proposed Rule

a. The Proposed Rule Addresses a Critical Need

According to the Proposed Rule, Indian Health Service (IHS), Indian tribes and tribal organizations (collectively, I/T/U) would cap the rates that they will pay for hospital services to what the Medicare program would pay for the same service (the "Medicare-Like Rate"). However, this Medicare-Like Rate cap applies only to hospital services, which represent only a fraction of the services provided through the PRC system. 25 C.F.R. § 136.30.

PRC programs continue to routinely pay full-billed charges for non-hospital services, including physician services. As data recently released by the Center for Medicare and Medicaid Services (CMS) demonstrate, full-billed charges may have no relationship to costs, and are dramatically higher than the rates Medicare, or even private insurance would pay for the same services.[2] Yet PRC programs remain the only entities other than the uninsured that continue to routinely be charged and pay full-billed charges for non-hospital services.

This has had a dramatic impact on the lives of Indian people. The PRC budget is significantly underfunded. As IHS noted in the Proposed Rule, it recently reported to Congress that IHS and tribal PRC programs denied an estimated $760,855,000 for an estimated 146,928 contract care services needed by eligible beneficiaries in FY 2013. The denial of needed services throughout the IHS system is endemic, and year after year it leads to unnecessary health care complications and the progression of otherwise treatable conditions.

Due to the lack of funding, PRC programs are routinely forced to ration care, and are often only able to authorize care in extreme “life or limb” scenarios. This rationing of care often results in otherwise preventable or treatable conditions going undiscovered until they become sufficiently acute that a referral can finally be authorized.

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[2] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html.

Tragically, and too often, this can result in patients whose conditions would have been treatable through early detection progressing to a point where treatment is no longer possible. It can also lead to simply medicating a condition rather than treating it.

The cost-savings achieved by expanding Medicare-Like Rates beyond hospital providers will allow PRC programs to allow higher priority levels of care. This will enable PRC programs to begin authorizing referrals for preventive care and diagnostics so critical to positive health care outcomes. It is also significantly more efficient, as the cost of preventive care and early detection is significantly lower than the referrals for acute "life or limb" treatment that PRC programs are often forced to limit themselves to approving.

b. The GAO Report Highlights the Need for Medicare-like Rates

In April 2013, the Government Accountability Office (GAO) issued a report concluding that the Medicare-like Rate Cap should be expanded to cover all services purchased under the contract-health services (CHS) program. The GAO concluded that "Congress should consider imposing a cap on payments for physician and other nonhospital service made through IHS's CHS program (now referred to as PRC) that is consistent with the rate paid by other federal agencies." The Department of Health and Human Services (HHS) reviewed the report and concurred with the GAO's conclusions and recommendations.

The GAO Report examined data for IHS's federal CHS programs, concluding that a cap on Medicare-like rates for nonhospital services would save the IHS CHS program an estimated $31.7 million annually.

The GAO found that the vast majority of federal CHS program payments were made at non-negotiated rates. The GAO reported that over 80 percent of IHS's federal CHS program payments to physicians for services were made at non-negotiated rates, totaling approximately $50.5 million. Additionally, GAO found that approximately 77 percent of federal CHS program payments to other types of nonhospital providers were made at billed rates rather than negotiated rates, totaling approximately $52.1 million.

The payment of non-negotiated rates cost IHS's federal CHS program significantly more than negotiated rates. The GAO estimated that federal CHS programs paid approximately twice as much as Medicare would have paid for the same services and one and a quarter times the amount that private insurance would have paid. The GAO found that where IHS CHS programs contracted rates, they saved approximately 58 percent in physician rates and approximately 68 percent in rates for other nonhospital providers.

The GAO concluded that applying a Medicare-like Rate cap to nonhospital services would allow IHS to spend its resources more effectively and provide approximately 253,000 additional physician services annually. The GAO stated that IHS is "a steward of public resources" and is therefore "responsible and accountable for using taxpayer funds efficiently and effectively." GAO emphasized that implementing a Medicare-like rate cap for all services purchased under the CHS program "would enable IHS to achieve needed savings that could be used to expand patient access to care."

c. *The Proposed Rule is Consistent with the Federal Trust Responsibility and Will Bring IHS in Line with other Federal Health Care Providers*

The United States has a federal trust responsibility to provide health care to American Indian and Alaska Native people, which has been recognized by Congress in numerous federal statutes, including the Snyder Act, 25 U.S.C. § 13; Johnson-O'Malley Act, 25 U.S.C. § 452; Transfer Act, 42 U.S.C. § 2001, *et seq.* (transferred responsibility for Indian health to Public Health Service); Indian Health Care Improvement Act, 25 U.S.C. §1601, *et seq.* (recently amended and permanently reauthorized as part of the Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010)). As Congress has stated: "Federal health services to maintain and improve the health of American Indians and Alaska Natives are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting trust responsibility to, the American Indian and Alaska Native people." 25 U.S.C. § 1601(1).

The current system results in the rationing of care, a result that is fundamentally at odds with the federal trust responsibility. While the Proposed Rule would not in and of itself provide full funding for PRC so as to meet all remaining unmet needs in Indian country, it would represent a giant step forward for the Administration in implementing the Federal Trust responsibility.

The Proposed Rule (as amended in our proposal) would bring IHS billing and payment policy in line 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. The VA, for example, has imposed a Medicare-Like Rate cap on the care it purchases for Veterans since 2010. 75 Fed. Reg. 78901 (Dec. 17, 2010). In addition, on November 5, 2014 the VA issued an interim final rule that would impose a Medicare-Like Rate cap on the services it was recently authorized by Congress to purchase through the Veterans Access, Choice, and Accountability Act of 2014 (Act), Pub. L. 113-146. The Proposed Rule would bring the IHS in line with the VA and other federal programs such as the Medicare program by making the rate the IHS pays for medical services consistent with the rates paid by other federal programs.

d. *The Proposed Rule's Potential Impact on Individual Providers is Likely to Be Minor*

While the Proposed Rule would provide an enormous benefit to the IHS and Tribal health care programs, its impact on individual providers is likely to be minor. One of the significant goals of this Administration is to lower the cost of health care in the United States. Yet current policy appears to allow the IHS and tribal programs to continue to pay full-billed charges for the health care services they purchase from non-hospital providers. Individual providers should not be able to continue to charge the most underfunded programs in the nation the highest rates for care. Those rates are often magnitudes higher than market rates, let alone the rates paid by other federal programs.

American Indians and Alaska Natives make up only 1 percent of the Nation's population, and as a result are in nearly every case a mere fraction of individual providers' patient loads. In its report, the GAO found that the expansion of Medicare-like Rates would not be likely to have a significant impact on physicians, including the top billers to PRC programs. The GAO interviewed physicians among the federal PRC programs' top 25 percent of physicians in terms of volume of paid services, and most of the physicians interviewed indicated that the CHS program constituted a small portion of their practice, accounting for 10 percent or less of their total payments. A

majority of the physicians interviewed supported capping PRC program payments at Medicare-like rates and identified several advantages, noting the savings to IHS, the decrease in the amount of time physician practices spend negotiating with different CHS programs, the fact that Medicare rates are already nearly universally accepted by physicians, and the fact that such a cap would lead to a consistent payment methodology.

Most hospital officials that the GAO interviewed stated that the current Medicare-like Rates requirements had little or no financial effect on their hospitals. However, the current Medicare-like Rate requirements, according to GAO interviews, allowed IHS and tribal programs to expand access to care. The same should hold true for practice groups and other types of non-hospital providers.

In addition, implementing Medicare-Like Rates for non-hospital providers will not impact total funding for the PRC program, which will remain unchanged. Because more AI/ANs will have access to care if Medicare-Like Rates are expanded, they will increase the volume of services being sought, which will result in providers achieving more volume to offset the decrease in rates.

e. *Provider Outreach and Monitoring and Reporting is Needed*

If the Proposed Rule is revised and implemented as suggested in these comments, IHS should engage in provider outreach and monitoring to ensure the rule is effectively implemented. Once a Final Rule is issued, the Director of Indian Health, in collaboration with tribes, should develop and issue a "Dear provider letter" for all I/T/U's to use to educate their network of providers regarding this regulation. Education and outreach to providers will be a critical component in successfully implementing the rule.

The IHS should also develop and implement a process in consultation with Tribes to monitor and report on the success of the Rule once it is implemented. As part of any Final Rule, the IHS should commit to developing a report within 12 months of the effective date of the rule, and annually thereafter, that would include an assessment of:

- The number of programs by region that have implemented the Rule;
- The actual number of PRC visits each year by region to demonstrate the increase in referrals seen by providers;
- The savings achieved by PRC programs by region;
- The number of providers by region who refuse to accept the rate, type of provider and location of that provider;
- Identify barriers to implementation of the Rule.

II. Summary of Attached Redline Revisions to Proposed Rule

As discussed above, while we support the Proposed Rule's goal in expanding a Medicare-Like Rate cap to non-hospital providers, we are concerned that the Rule as drafted is too inflexible and could result in significant diminution in access to care in different areas of the country. We have provided suggested revisions to the Proposed Rule which we believe are necessary to provide the flexibility some PRC programs need to ensure continued access to providers while maintaining the integrity of Medicare-Like Rates as a general rule. We provide a narrative summary and justification for our proposed changes below.

a. *The Proposed Rule Should Not Imply that Professional Services Are Never Covered by the Existing Medicare-Like Rate Regulations*

The Title to Subpart I is "Limitation on Charges for Health Care Professional Services and Non-Hospital-Based Care." Similarly, the Title for Section 136.201 is "Payment for physician and other health care professional services purchased by Indian health programs and other medical charges associated with non-hospital-based care." Both titles suggest that care provided by physicians and other health care professionals is never subject to the current Medicare-Like Rate regulations. That is not the case.

The current Medicare-Like Rate regulations apply to "all Medicare-participating hospitals, which are defined for purposes of this subpart to include all departments and provider-based facilities of hospitals (as defined in sections 1861(e) and (f) of the Social Security Act) and critical access hospitals (as defined in section 1861(mm)(1) of the Social Security Act), that furnish inpatient services …." 25 C.F.R. § 136.30(a). The payment methodology of the current regulations applies to "all levels of care furnished by a Medicare-participating hospital, whether provided as inpatient, outpatient, skilled nursing facility care, as other services of a department, subunit, distinct part, or other component of a hospital (including services furnished directly by the hospital or under arrangements) …." 25 C.F.R. § 136.30(b).

This includes physicians and other health care professionals if they are employed directly by the hospital or even "under arrangements." As a result, if the hospital bills for a professional's services as part of the hospital (i.e., under the same provider number), then the existing Medicare-Like Rate regulations apply.

We propose edits to the Proposed Rule to clarify that it applies to all non-hospital providers (including non-hospital based physicians and other health care professionals).

b. *§ 136.201(a)(1)(3)*

Section 136.201 of the Proposed Rule states that I/T/Us may only pay 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." We are concerned that the criterion the amount the provider "bills the general public" for the same service is too vague. The term "general public" is subject to multiple interpretations. We believe the intent of the provision is to cover the amount the provider "accepts as payment for the same service from nongovernmental entities, including insurance providers."

c. *Need for Exceptions in New Section 136.201(b)*

Section 136.201(a) of the Proposed Rule provide that that Medicare-Like Rates are the highest rates the IHS could pay. As summarized in the Preamble, "The rule caps the rate that I/T/Us are authorized to pay non-I/T/U health care providers and suppliers for services and leaves no discretion for the I/T/U and the health care provider to negotiate higher rates."

While this lack of discretion is likely intended to make the rule as strong as possible, it renders it unworkable in many areas in Indian country. We are concerned that the absolutist approach taken in Section 136.201(a) will deny many I/T/Us the discretion and flexibility they need to deal with unique circumstances that may necessitate negotiating a rate that is different from, or even higher than, the Medicare-Like Rate. Flexibility is one of the

foundational principles underlying the Indian Self-Determination and Education Act and Tribes and Tribal Organizations who negotiate agreements under that Act with the IHS should have the right to choose not to apply this new rule if they choose to do so. Similarly, urban Indian organizations should be given this same right to ensure that they can decide for themselves if they want the rule to apply.

Further, unless the Proposed Rule is amended to allow for the possibility of an exception to the general rule, it will operate to deny access to certain providers who will refuse to take the Medicare-Like Rate. This is particularly true in rural areas where access to care is more limited, and certain types of providers may be the only accessible provider of that type. If there is no possibility for an exception to this rule, certain providers may simply refuse to see patients, necessitating referrals to other providers so distant that the cost of traveling to see them will negate any benefit from requiring payment at the Medicare-Like Rate.

The VA recognized access to care could be an issue, and has implemented its Medicare-Like Rate regulations to address access to care issues in both Alaska and the lower 48 states. 38 C.F.R. §§ 17.56(a); 17.1535. We believe the IHS must adopt a similar approach in its Rule. We offer the following exception to implement this needed approach.

i. *Exception at Election of I/T/U*

As discussed above, in order for the rule to work, it is imperative that it contain a "safety valve" that would allow Indian health care providers to negotiate a different rate than the rates set out in Proposed Section 136.201(a) in order to ensure continued access to care. We propose have proposed two new provisions that offer safety valves for I/T/Us in different circumstances around the country.

The first provision, set out in section 136.201(b) (1), is designed for Tribes and Tribal Organizations who have negotiated agreements with the Indian Health Services under the Indian Self-Determination and Education Act and urban Indian organizations, and makes it clear that they have the right to choose for themselves not to apply this rule.

We also propose that a new Section 136.201(b) (2) be added to the Proposed Rule. This new section would allow I/T/Us, when necessary, to negotiate a rate with providers that is higher than the rate provided for in Proposed Section 136.201(a). However, we also propose that such rate be capped at no more than what the provider certifies to the I/T/U that it charges non-governmental entities, including insurance providers, for the same service. This structure should provide I/T/Us the flexibility they may need to ensure continued access to care from certain providers, while at the same time ensuring that rates of payment are no more than what other non-governmental entities pay for the same services.

III. Request for Tribal Consultation on the Proposed Rule

The Proposed Rule would have significant Tribal implications and substantial direct effects on one or more Indian Tribes. As a result, pursuant to the HHS Tribal Consultation Policy, Tribal Consultation is required. While [[Insert Tribe name]] welcomes the opportunity to comment on the Proposed Rule through the notice and public comment

process required by the Administrative Procedure Act, the HHS, acting through the Director of the IHS, must also engage in Tribal Consultation on the Proposed Rule before any action is taken to finalize the rule.

USET appreciates the opportunity to provide comments on the Proposed Rule and looks forward to being able to engage in additional Tribal Consultation on the proposal as well. Should you have 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,

Brian Patterson
President

Kitcki A. Carroll
Executive Director

CC: USET member Tribes
Wanda Janes, USET Deputy Director
Dee Sabattus, USET THPS Director
Liz Malerba, USET Policy and Legislative Affairs Director
Hilary Andrews, USET Health Policy Analyst
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