

January 20, 2015

Yvette Roubideaux, MD, MPH
Acting Director
Indian Health Service
The Reyes Building
801 Thompson Avenue
Rockville, Maryland 20852

Dear Dr. Roubideaux:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the proposed rule issued by the Indian Health Service (IHS) to change the payment framework for physician and other health care professional services purchased by Indian Health programs and medical charges associated with non-hospital-based care. The IHS proposes to amend the Purchased and Referred Care (PRC) regulations to apply Medicare-like payment methodologies to all physician and other health care professional services and non-hospitalized-based services that are authorized under such regulations or purchased by urban Indian organizations (UIOs). The AMA is concerned that rather than expanding beneficiary access, which is the stated goal of the proposed change, reducing payments to physicians will actually result in less beneficiary access to medical care.

Under the proposed rule, the health programs operated by IHS, Tribe, Tribal organizations, or UIOs (collectively, I/T/U programs) would pay the lowest of the amount provided under the applicable Medicare fee schedule, prospective payment system, or Medicare waiver; the amount negotiated by a repricing agent, if available; or the usual and customary billing rate. The rationale for this proposal is that I/T/Us historically have paid rates that are substantially more than Medicare allowable rates or rates paid by private insurers for the same services, and that despite establishing medical priorities to cover the most necessary care, IHS is still unable to provide care to all of its beneficiaries. The IHS relies upon a 2013 Government Accountability Office (GAO) study that concluded the IHS could increase the pool of money available in the PRC program, thereby expanding beneficiary access to care, by setting PRC physician and other non-hospital payments at rates consistent with Medicare and other Federal agencies.

However, under the proposal, physicians would not necessarily receive the Medicare fee schedule rate, but could receive a lower amount, as specified by the options in the proposed regulatory text. We strongly urge IHS to reconsider this change. Relying upon a broken Medicare reimbursement system, with a flawed sustainable growth rate (SGR) methodology, does not make sense. IHS should retain the current system that allows physicians to negotiate their rates or receive their billed charges. At the very least, the proposed language that provides IHS would pay the lowest of the amount under the fee schedule, the amount negotiated by a repricing agent, or the usual and customary billing rate, should be deleted. Instead, physicians who agree to participate in the PRC program should receive at least the

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Medicare rate, which would be consistent with payment under other Federal programs, such as the new Veterans Choice Program being implemented by the Veterans Administration. If IHS' proposed regulatory text is not amended, we strongly urge IHS to allow exceptions to be incorporated into the rule to allow I/T/Us more flexibility to pay higher amounts in situations where a beneficiary needs care provided by a specific physician who does not agree to the reduced rates under the PRC program, or in remote areas where there may only be one or two available physicians.

While the AMA understands the great need for PRC services by IHS beneficiaries, who suffer disproportionately from a variety of health afflictions including, heart disease, cancer, diabetes, and tuberculosis, we strongly believe that reducing physician payments will provide a disincentive to physicians to participate in the PRC program, and will result in less beneficiary access to care. This has happened in the Medicaid program, where low reimbursement rates have kept many physicians from participating. Moreover, delays in payment to physicians who agree to see IHS beneficiaries have created disincentives for increased participation in the PRC program. In a 2013 report, the GAO found that the majority of provider payments were received up to six months after service delivery, while some payments took more than one year. The GAO has made numerous recommendations on ways for the IHS to improve its administration of the PRC program, including improvements to the timeliness of its payments to providers. We believe that making such improvements could help to improve beneficiary access to services, rather than cutting payments to physician and non-hospital providers.

Thank you for considering our comments. If you have any questions, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

/James L. Madara, MD/

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