



Bois Forte

TRIBAL GOVERNMENT

SUBMITTED VIA: <http://regulations.gov>

February 3, 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

REF: 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);
RIN 0917-AA12

Dear Ms. Gould & Mr. Harper:

The Bois Forte Reservation is writing to provide you with our comment and recommendations on the Indian Health Service's (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) (the "Proposed Rule").

Preamble

The Bois Forte Reservation is included in the Bemidji Area I.H.S. The closest hospital that we have access to under I.H.S. is in Cass Lake, Minnesota which is over 100 miles one way for inpatient health care services. Therefore the Bois Forte program is commonly referred to as "Contract Health Services (CHS*) Dependent" because we must purchase all specialty care through the Purchased and Referred Care (PRC) program (*the CHS program has been renamed PRC and CHS/PRC terms are used interchangeably by Tribes). The Bois Forte Tribe is also a small rural tribe that also lacks the administrative capacity to negotiate provider agreements, adjudicate claims, and conduct other business office functions that are beneficial with large hospital and health clinic staffing packages.

Thus any changes that are made, or proposed in the PRC program, must be careful to not adversely impact the effectiveness of all tribal PRC programs including Bois Forte. Any change to improve the efficiency or financial operations of the PRC program must be carefully evaluated to ensure that they do not impose additional administrative or financial burden on the PRC program and the patients they serve.

5344 Lakeshore Drive | Nett Lake, MN 55772 | 218-757-3261 | 800-221-8129 | FAX 218-757-3312

Kevin W. Leecy
Chairman

David C. Morrison, Sr.
Secretary/Treasurer

Brandon Benner
District I Representative

Karlene D. Chosa
District I Representative

Ray Toutloff
District II Representative

Otherwise, a meaningful and well-intentioned change could actually restrict patient access and likely cost the program more resources than it would save.

The Bois Forte Tribe strongly supports expanding Medicare-Like Rates beyond hospital-based providers. We support the Proposed Rule as a positive first step toward achieving this goal, however as drafted the Proposed Rule will simply not work for Tribes. The Proposed Rule does not provide the flexibility that is necessary to ensure continued access to specialty care for the PRC program. 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 and result in unnecessary financial burden on patients.

We discuss below recommendations that we believe will improve the effectiveness of the rule for PRC programs. We stress that the Proposed Rule cannot work without the adoption of these recommendations. As a result, the Bois Forte Tribe cannot support the Proposed Rule without these revisions and if IHS cannot agree to include them in the Final Rule than this Proposed Rule should be withdrawn by the Agency.

The following are our general comments and recommendation on the Proposed Rule.

Comments and Recommendations

As discussed above, while we support the Proposed Rule's goal to expand Medicare-Like Rates to non-hospital providers, we are concerned that the Proposed Rule as drafted is too inflexible. It will result in a significant diminution in access to PRC care. We have provide suggested revisions to the Proposed Rule which we believe are necessary to provide the flexibility for PRC programs to ensure continued access to providers while maintaining the integrity of Medicare-Like Rates as a general-rule. The following is a summary and justification for our proposed changes.

I. 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." The preamble of the rule also states that, "The Medicare-like rate methodology established by 42 CFR part 136 subpart D does not apply to non-hospital services, including physician and other health professional services, services provided by a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice, or other nonhospital-based items and services."¹ Both titles suggest—and the preamble states—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 and the Proposed Rule should be modified to avoid this unnecessary confusion.

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

¹ See Federal Register Vol. 79, No. 234, Friday, December 5, 2014, p. 72161.

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.

- a. We recommend that IHS modify the title of the Proposed Rule to clarify that it applies to all non-hospital providers (including non-hospital based physicians and other health care professionals) and make conforming amendments in the preamble and throughout the Proposed Rule as follows:

Revise title and new subpart as follows:

“Subpart I—Limitation on Charges for Health Care Professionals and Non-Hospital-Based Care”

Revise § 136.201 as follows:

§ 136.201 Payment for physician and other health care professional services purchased by Indian health programs and other medical charges associated with non-hospital-based care.

(a) Payment to physicians and health care professionals and all other for non-hospital-based entities, including non-hospital based physicians and professional services, for any level of care authorized under part 136, subpart C by a Purchased/Referred Care (PRC) program of the Indian Health Service (IHS); or authorized by a Tribe or Tribal organization carrying out a PRC program of the IHS under the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93-638, 25 U.S.C. 450 et seq.; or authorized for purchase under § 136.31 by an urban Indian organization (as that term is defined in 25 U.S.C. 1603(h)) (hereafter “I/T/U”), shall be determined based on the applicable method in this section: The I/T/U will pay the lowest of the following amounts:

- b. § 136.201(a)(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.”

Revise § 136.201(a)(3) as follows:

(3) The amount that the provider or supplier bills accepts as payment for the same service from nongovernmental entities, including insurance providers the general public for the same service.

II. The Proposed Rule must include a new "Exceptions" clause as 136.201(b)

Section 136.201(a) of the Proposed Rule provides that the 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." This means that unless providers "willingly" accept the rate that I/T/U's may not authorize PRC services with the provider. Often there are "facility-based" and non-facility based services associated with PRC referrals, or travel costs might exceed savings, than the Proposed Rule may actually restrict access and increase costs.

While this lack of discretion is likely intended to make the rule as strong as possible, it is impractical to expect that all non-hospital based providers will accept Medicare-Like Rates through the imposition of IHS' purchasing power. If this were the case than the sheer market forces of IHS purchasing power would have already dictated the negotiation and acceptance of lower than full billed charges and acceptance of Medicare-Like Rates. There would not be a need for Medicare-Like Rate legislation similar to 42 CFR § 136.30 "Payment to Medicare participating hospitals for authorized Contract Health Services" and proposed legislation pending before Congress to extend Medicare-Like Rates for non-hospital based services.

The absence of an Exclusions clause renders the Proposed Rule unworkable in many areas in Indian country and will likely have the greatest effect on PRC dependent Tribes such as Bois Forte. We are concerned that this *all or nothing* approach taken in Section 136.201(a) will cause an undue and administrative burden for I/T/U programs to ferret out providers that are willing to accept Medicare-Like Rates since the Proposed Rule is not conditioned on participation in the Medicare program.

The rule denies I/T/Us the discretion and flexibility to deal with unique circumstances that may necessitate negotiating a rate that is different from, or even higher than, the Medicare-Like Rate. The Proposed Rule must be allow for local flexibility to pay higher rates when such things as travel costs would exceed any cost savings associated with paying Medicare-Like Rates. Additionally, quality of care and timeliness of health services should also be considerations when travel distances or travel time would affect patient care.

Most importantly, tribal sovereignty and self-determination must also be respected to allow Tribes the flexibility to negotiate with providers and determine how best to meet the needs of their community when providing health care. 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.

Finally, we believe the IHS must adopt a similar approach that the Veterans Administration has adopted in a similar rule.² If this cannot be done, than IHS should rescind the Proposed Rule. 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.

a. *Recommend Exception at Election of I/T/U*

² The Veterans Administration 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.

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 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.

Recommendation for new "Exception" clause at 136.201(b) :

(b) Exception.

(1) Subpart (a) shall apply to a Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93-638, 25 U.S.C. 450 et seq., and urban Indian organizations (as that term is defined in 25 U.S.C. 1603(h) only at the election of the Tribe, Tribal organization or urban Indian organization.

(2) The I/T/U, either directly or through a repricing agent, may elect to negotiate a rate that is more than the rate described in paragraph (a) of this section with a non-hospital based entity, but in no event shall such rate be higher than the lowest rate the non-hospital based entity certifies to the I/T/U that it accepts as payment for the same service from nongovernmental entities, including insurance providers.

III. Request for Tribal Consultation on the Proposed Rule

The IHS and HHS Tribal Consultation Policies require that the Department and Agency to consult with Tribes in the development of any policies that will have direct effects, Tribal implications, or place a substantial direct compliance cost necessary for Tribes to meet the requirements of a policy or regulation. The Agency did not consult with Tribes in a meaningful way to development the Proposed Rule despite repeated Tribal requests and the Agency's espousal that it did consult. An excellent example of how the IHS and CMS consulted with Tribes in deliberate and meaningful manner was the consultative process used to develop the regulations for Payment to Medicare-participating hospitals for authorized Contract Health Services (42 CFR 136.30). A similar process should be followed by the IHS in the development of the Proposed Rule.

Moving forward, the Proposed Rule will have significant Tribal implications and substantial direct effects on one or more Indian Tribes. As a result, pursuant to the IHS and HHS Tribal Consultation Policies, Tribal Consultation is required. While the Bois Forte Tribe 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. Tribal Consultation with IHS should not be relegated to the Administrative Procedures Act this is unprecedented.

IV. The Proposed Rule's Potential Impact on Individual Providers is Likely to Be Diffuse and De Minimus

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 diffuse and *de minimus*. A goal of this Administration, and in Congress, 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 a small fraction 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.

V. Training for Tribes, Provider Outreach, and Monitoring and Reporting are Needed

If the Proposed Rule is revised and implemented as suggest in these comments, IHS should develop a training and technical assistance initiative to prepare I/T/U sites to implement the rule. Tribes expressed their concern about the lack of training and technical assistance associated with implementing the regulations for Payment to Medicare-participating hospitals for authorized Contract Health Services (42 CFR 136.30). The adjudication of non-hospital based claims are more complex and the availability of repricing software will be expensive as demonstrated with the 42 CFR 136.30 regulations. IHS should work with software vendors to select 1-3 software products that the I/T/U can use and negotiate a volume discounts for Tribes to purchase the software. Training and technical assistance should be provided by the software vendors and by IHS. The effective date of the regulation should allow time for Tribes to select and purchase software, undergo training and technical assistance to implement the rule, conduct community and provider education, and to develop and implement internal controls associated with implementation of the rule.

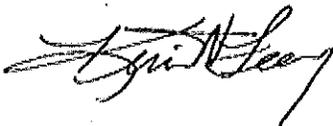
IHS should also engage in provider outreach and monitoring to ensure the rule is effectively implemented. Once a Final Rule is issued, the Director of Indian Health, in collaboration with tribes, should develop and issue a "Dear provider letter" for all I/T/U's to use to educate their network of providers 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.

We look forward to revised rule so that it is manageable for Tribes. We also look forward to working and consulting with IHS to refine the Proposed Rule so that is operational and manageable for Tribes. Thank you for the opportunity to submit these comments.

Sincerely,



Kevin W. Leecy
Chairman