

Purchased/Referred Care Rates FAQs

Final Rule:

1. How much involvement or enforcement do we have?

There is not a specific enforcement mechanism in the rule; however, the rule provides that the provider/supplier shall be deemed to have accepted the PRC rates, if the provider/supplier does any of the following: provides services based upon a PRC referral, submits a notification of a claim for payment to the I/T/U, *or* accepts payment for the provision of services from the I/T/U. Federal law also prohibits the provider from billing the patient for authorized care.

2. How does Tribal Self-Insurance fall in line with these rates?

The PRC rates rule only applies to services purchased by the following: IHS PRC programs; Urban Indian organizations pursuant to 42 C.F.R. 136.31; or tribally operated PRC programs, if the Tribe/Tribal organization chose to opt-in. PRC programs are the payor of last resort by statute and this rule does not change that status, but it further clarifies coordination of benefits and limitation on recovery under 42 CFR 136.203(b)(1). Under the coordination of benefits provisions, PRC is a residual resource and pays after all other resources have considered the claim. Since Tribal self-insurance plans are not PRC programs, the PRC rates rule does not address the amount these plans will pay for services, but the rule incorporates that plan's responsibility for payment relative to the PRC program under the payor of last resort statute.

3. Can Tribal programs opt-in to the rule and how do they opt-out?

Yes, Tribes can opt-in to the rule. The requirements of the PRC rate rule will not apply to a tribally operated PRC program until the necessary opt-in language is included in its contract/compact with IHS. Tribes should contact their Area contract proposal liaison officer or Area lead negotiator to modify or amend their contract/compact.

4. For a Tribe to opt-in to the rule, what language needs to be included in the AFA?

Tribes should contact their Area contract proposal liaison officer or the Area lead negotiator to obtain a copy of the recommended language to modify or amend existing contracts and compacts for the purpose of the opt-in.

5. If Tribes find that the rates are not working for them, can they opt-out? If a Tribe opts-out will this hinder their ability for PRC eligibility?

Yes, after a Tribe or Tribal organization opts-in, it can effectively opt-out if they find the rates are not working for their PRC program. Tribes would again contact their contract proposal liaison officer or Area lead negotiator to amend or modify the language in their contract/compact. Opting out will not hinder a tribe's eligibility for PRC.

6. How does this differ from MLR for hospital services?

This rule does not change the prior existing hospital-based rate rule developed by IHS under 42 C.F.R. part 136 subpart D. The newly promulgated PRC rate rule, under Subpart I, applies to services provided by entities that are *not* subject to Part 136 subpart D.

7. Payer of last resort and the ACA revision?

This rule does not change the payer of last resort.

8. Can Tribes do a partial opt-in or does it have to be a total opt-in?

The flexibility added for Tribally-operated PRC programs only permits a total opt-in. IHS included flexibility into the rule to allow PRC programs to negotiate rates with providers that are based on the provider's most favored customer rates or are otherwise fair and reasonable, as determined by the I/T/U.

9. Can you provide the opt-in language for Tribal programs? What do we do if we want to opt-out half-way through a multi-year agreement, do we have to modify the whole agreement?

The language is recommended, not mandatory, and it is available from your CPLO or ALN. If, after opting in, a Tribe or Tribal organization chooses to opt-out during their contract period, they will simply need to modify or amend the relevant provision in their contract/compact.

10. How does this rate affect providers that we pay at per diem?

The rule provides certain flexibility to negotiate a rate with those providers or, if they choose to provide PRC services without a negotiated rate, the providers will need to accept the PRC rate.

11. I'm in a rural area, how does this affect or impact the providers that we pay at per diem?

The rule provides flexibility to negotiate higher rates when the prices are fair and reasonable and the purchase of the service is otherwise in the best interest of the I/T/U, as determined by the I/T/U.

12. Will the opt-in and opt-out instructions be included in the Dear Tribal Leader Letter?

Yes.

Training

13. When will training begin?

As soon as possible. IHS plans to conduct in-person, online, module and conference call training. IHS will host the first Webinar on May 17. Each Area PRC Officer will be sent an email notifying them of the PRC Rates Webinar, which they will share with both federal and

tribal PRC programs. This notice will be posted to the IHS/CHS Website. The OIT/ORAP Partnership meeting is scheduled for June 28, 29 and 30 in Phoenix, Arizona and training on the PRC rates will be provided for both federal and tribal PRC administrators.

14. When will the Dear Tribal Leader letter and Provider letter be available?

They were mailed out on May 25th and IHS will post them to the PRC (CHS) website. The provider letter will also be sent to IHS' Fiscal Intermediary so that they can include copies with checks and assist in provider education.

15. How can we get access to the training Webinar?

HQs staff will send out a notification and post to the PRC (CHS) website.

Fiscal Agents:

16. Does CMS provide pricing software? The cost to purchase the components individually could be \$100,000.

Options will be provided during the training plus the IHS fiscal intermediary will price for IHS and tribal programs that use the FI.

17. Can a list of fiscal agents be provided to the Tribes?

IHS does not currently have a list of pricing agents. IHS uses a fiscal intermediary to process its claims, but IHS understands that certain tribes may already engage the services of fiscal agents or may choose to do so in the future, and for this reason, IHS included this flexibility in the final rule.

Savings:

18. What mechanism is in place to track savings? Will this be cross referenced to those States with Medicaid expansion?

The final rule does not provide a mechanism for tracking overall savings, but the individual programs will be able to track their own savings and confer with one another on best practices.

19. If you are negotiating with different providers, can you negotiate with some and use the PRC rates with others?

Yes, as long as the negotiated rates comply with the final rule.

20. There is no schedule for some services e.g., anesthesiologists, can we get a tool with a generic list for the Most Favored Customer Rate?

IHS does not currently have a generic list for most favored customer rates, but the final rule provides that the allowable amount shall be deemed to be 65% of the authorized charges

when no Medicare rate exists and the other methodologies provided in 136.203(a)(1) or (2) are not assessable or available.

21. What is Medicaid's responsibility in this Rule?

Medicaid does not have any responsibility for implementing or enforcing this final rule. IHS promulgated this rule pursuant to its own rulemaking authority. Medicaid will be responsible for payment as an alternate resource to the PRC programs, but this final rule does not change that responsibility or the amount Medicaid will pay to the provider/supplier. However, the final rule provides that payment made by Medicaid "is considered payment in full and there will be no additional payment made by the I/T/U." 42 CFR 136.203(b)(5).