

FI Questions Comments

A health program operated by the IHS or by an urban Indian organization through a contract or grant under Title V of the Indian Health Care Improvement Act (IHClA), Public Law 94–437 must implement the rates specified herein **no later than March 21, 2017**. The rule will apply to outpatient services provided after **May 20, 2016**. The rule will apply to inpatient services with an admission that falls on or after the effective date of the rule.

1. If the rule applies on May 20, but does not have to be implemented until March 2017, what is the expectation on the FI's processing of the claims that fall in the timeframe?

Response: The FI should work to be ready to process claims in accordance with the methodologies specified in the final rule after May 20, 2016. While the rates have to be implemented no later than March 21, 2017, PRC programs should implement the rule as soon as possible and can use the rates as of May 20, 2016.

2. If an Area is ready to implement how will the FI know?

Response: IHS is developing a process for notifying the FI and making revisions to its forms, which will provide additional information to the FI for purposes of payment. For the time being, the Area Office will indicate on the Purchase Order (PO) that the PRC rates apply by checking the "Other" box and adding "42 CFR part 136 Subpart I." The Area Offices will also continue submitting updated contracts to the FI, to notify the FI that there is a new negotiated rate.

3. What action should the FI take if a Tribe is ready to implement and the FI is not set up?

Response: The FI should pay the claims in accordance with the applicable methodology. The FI should be able to timely process the claims using the information on the PO or equivalent form. If needed, the FI can seek clarification from the Tribe regarding the applicable methodology.

IHS has added an applicability provision in § 136.201. This provision specifies that the rule applies to IHS-operated PRC programs, urban Indian health programs, and Tribally-operated programs, but only to the extent the **Tribally-operated programs opt-in** to the requirements of the rule.

4. How will IHS let the FI know if a Tribal Program has opted in?

Response: The FI Project Officer will work closely with the Office of Tribal Self-Governance and the Office of Direct Service and Contracting Tribes to obtain the names of the Tribes that have chosen to opt-in to the rule. An Excel spreadsheet listing the Tribes will be maintained and provided to the FI.

5. For those Tribes that opt in, can they opt-out at a later time? And conversely, if a tribe opts out can they opt in at a later time? How often can they do this?

Response: Tribes can opt-in and subsequently opt-out of the rule at any time and as often as they would like, so long as the change is noted in their contract/compact with IHS; it's a Tribal decision.

IHS also agrees with Tribal stakeholders that Tribes should be provided more flexibility to negotiate rates that exceed Medicare rates and agrees that controls should be put into place to ensure that negotiated rates remain fair and reasonable. Section 136.203 provides that **if a specific amount has been negotiated with a specific provider or supplier or its agent by the I/T/U, the I/T/U will pay that amount, provided such amount**

is equal to or better than the provider or supplier's MFC rate, as evidenced by commercial price lists or paid invoices and other related pricing and discount data, to ensure the I/T/U is receiving a fair and reasonable pricing arrangement. Further, **the MFC rate does not apply if the I/T/U determines the prices offered to the I/T/U are fair and reasonable and the purchase of the service is otherwise in the best interest of the I/T/U.** It will be incumbent on the provider of services to provide the necessary documentation to ensure the rates charged are fair and reasonable.

6. If the rule applies on May 20, but does not have to be implemented until March 2017, what is the expectation on the FI's processing of the claims that fall in the timeframe?

Response: See response to question #1.

7. Who is responsible for the controls that need to be put in place to ensure negotiated rates remain fair and reasonable?

Response: The Tribe or IHS determines whether the negotiated rates are fair and reasonable. The FI is not responsible for ensuring negotiated rates remain fair and reasonable.

8. Will the negotiated rate continue to come to the FI, as a contract? Especially since the FI does not have access to a provider's/supplier's MFC rate.

Response: Yes. The FI will continue to receive the contract or agreement.

9. If the rates are deemed to be fair and reasonable, how will the FI be notified?

Response: The FI will receive a purchase order (or its equivalent), contract or agreement identifying the rate that should be paid.

10. For those rates that are deemed to be fair and reasonable, will it apply to all of the provider's claims or only for certain services?

Response: The rates can apply to all of the provider's claims or only certain services, depending upon how the rates were negotiated with the provider.

IHS intends to work with Tribes to educate the providers that participate in IHS and Tribal PRC programs.

11. How does IHS see the FI participating in provider education?

Response: The IHS will instruct the FI to do check stuffers with relevant information for PRC providers.

...provisions have been inserted providing for payment not to exceed the provider or supplier's MFC rate, as evidenced by commercial price lists or paid invoices and other related pricing and discount data to ensure that the I/T/U is receiving a fair and reasonable pricing arrangement.

12. How will the FI be notified of the provider's/supplier's Most Favorable Customer rate? Will this be on a contract?

Response: The FI is not responsible for determining or verifying the MFC rate; the FI should pay the amount agreed upon in the contract or rate quote agreement.

13. How often can the MFC rate change?

Response: There is no limit on how often the agreed upon rate can change, but the FI is not responsible for determining or verifying the MFC rate. When the rate changes, it is incumbent on the PRC program to notify the FI of a rate change.

Additionally, in the event that a Medicare rate does not exist for an authorized item or service, and no other payment methodology provided by the rule is applicable, IHS has included a provision in 136.203(a)(3) that authorizes payment at 65% of **authorized charges**.

14. Will this clause also be stipulated in the contracts? Tribes utilize different percentages, for example 70% of billed charged.

Response: This provision applies in the absence of a negotiated rate, meaning that there is no percentage set forth in a contract. If a specific percentage is stipulated in the contract, this clause would not apply and the contract would control the reimbursement rate.

15. Define Authorized Charges (the amount on the PO, allowed, or billed charge)?

Response: The “authorized charges” are 65% of the allowed charges for the services authorized. The FI should consult the agreement between IHS and the FI to determine which line items should be excluded.

IHS notes incurring financial responsibility may be avoided by obtaining a **PRC authorized referral** from IHS prior to treatment. If a **referral** is issued by IHS, it means that the provider has accepted IHS payment rates, and the patient may not be charged for the service.

16. Will the referral replace the PO? If so, what will the format be?

Response: No, the referral is not replacing the PO, but the referral might be the PO. The term “referral” was intended to encompass situations where issuing a PO in advance was impossible or impracticable, but the IHS intended to authorize care.

17. What happens if a referral/PO is not issued timely? Will the patient still be charged and/or possibly sent to collections? This could cause a lawsuit.

Response: If the FI receives a claim without a PO, the FI should not pay the bill. If IHS does not issue a referral, as defined by the rule, or a PO, IHS has not authorized the services. If the patient self-refers and notifies us within 72 hours IHS will look at these on a case-by-case basis.

A health program operated by the IHS or by an urban Indian organization through a contract or grant under Title V of the IHCA, Public Law 94–437 should implement the rule as soon as possible, but must implement the rates specified herein no later than one year from the date of publication in the Federal Register.

18. See questions #1 - 3

Response: See the responses to questions #1-3.

Repricing agent means an entity that offers an IHS, Tribe or Tribal organization, or urban Indian organization (I/T/U) discounted rates from non-I/T/U public and private providers as a result of existing contracts that the non-I/T/U public or private provider may have within the commercial health care industry.

19. Please explain what a repricing agent does?

Response: A repricing agent is an intermediary who negotiates rates on behalf of another entity. IHS does not utilize repricing agents. If a tribe utilizes a repricing agent, the tribe can provide the negotiated rates to the FI.

If a specific amount has been negotiated with a specific provider or supplier or its agent by the I/T/U, the I/ T/U will pay that amount, provided that such amount is equal to or better than the provider or supplier's Most Favored Customer (MFC) rate, as evidenced by commercial price lists or paid invoices and other related pricing and discount data to ensure that the I/T/U is receiving a fair and reasonable price. The MFC rate limitation shall not apply if:

- (i) The prices offered to the I/T/U are fair and reasonable, as determined by the I/T/U, even though comparable discounts were not negotiated; and
- (ii) The award is otherwise in the best interest of the I/T/U, as determined by the I/T/U.

MFC applies even if we determine the MFC is fair and reasonable.

20. Will the determination of fair and reasonable be for a provider (a doctor's group, DME provider) regardless of service provided?

Response: The rates can apply to all of the provider's claims or only certain services, depending upon how the rates were negotiated with the provider. The FI is not responsible for determining or verifying whether the rate is fair and reasonable; the FI should pay the amount agreed upon in the contract or rate quote agreement.

21. Will the determination of fair and reasonable be for a provider's service (mammograms, wheelchair rental)?

Response: See response to question #20. The agreement could specify rates for individual services or one rate for various services.

If an amount has not been negotiated in accordance with paragraph (a)(1) of this section, the I/T/ U will pay the lowest of the following amounts:

- (i) The applicable Medicare payment amount, including payment according to a fee schedule, a prospective payment system or based on reasonable cost ("Medicare rate") for the period in which the service was provided, or in the event of a **Medicare waiver**, the payment amount will be calculated in accordance with such waiver.
- (ii) An amount negotiated by a repricing agent if the provider or supplier is participating within the repricing agent's network and the I/T/U has a pricing arrangement or contract with that repricing agent.
- (iii) An amount not to exceed the provider or supplier's MFC rate, as evidenced by commercial price lists or paid invoices and other related pricing and discount data to ensure that the I/ T/U is receiving a fair and reasonable price, but only to the extent such evidence is reasonably accessible and available to the I/T/U.

In the event that a Medicare rate does not exist for an authorized item or service, and no other payment methodology provided for in paragraph (a)(1) or (2) of this section are accessible or available, the allowable amount shall be deemed to be 65% of authorized charges.

Authorized Services: Authorized services: Payment shall be made only for those items and services authorized by an I/T/U consistent with this part 136 or section 503(a) of the IHClA, Public Law 94-437, as amended, 25 U.S.C. 1653(a) ... (f) No service shall be authorized and no payment shall be issued in excess of the rate authorized by this section.

22. What is a Medicare waiver? Does this mean a specific provider is paid special rates, under demonstration

projects or Medicare Shared savings programs?

Response: A Medicare waiver would be a waiver from the Medicare methodologies. A provider could be paid special rates, under demonstration projects or Medicare Shared savings programs. IHS will ask the providers to specify when they should be paid according to a waiver.

23. Do any IHS/Tribal programs use a repricing agent?

Response: IHS does not use a Repricing Agent. Tribes may, but IHS does not have any data on this for the Tribes.

24. How do blanket purchase orders factor into this regulation?

Response: The FI will pay the applicable rate on the PO.

25. How about Dental charges? Dental is not covered by Medicare?

Response: Some services may be covered under Medicare, such as oral surgery. In the absence of a Medicare rate and the absence of a negotiated rate, the appropriate rate is 65% of the authorized charges.

26. Should the FI only pay charges based on the information provided on the Referral (PO)? Additional tests/procedures should not be paid?

Response: The FI should pay the authorized charges for the specific services authorized on the purchase order.