

National Indian Health Board



Submitted via: www.regulations.gov

October 31, 2016

Terri Schmidt
Acting Director
Office of Resource Access and Partnerships
5600 Fishers Lane
Mail Stop: 09E70
Rockville, MD 20857

Re: Catastrophic Health Emergency Fund (CHEF) Proposed Rule Additional Comments

Dear Ms. Schmidt:

On behalf of the National Indian Health Board (NIHB), I write to provide additional comments in response to the Indian Health Service's (IHS) proposed regulation for the Catastrophic Health Emergency Fund (CHEF), which was published in the Federal Register on January 26, 2016. NIHB and initially closed on May 11, 2016. We are grateful that the Indian Health Service is dedicated responded to our request for further Tribal consultation on this topic by extending the comment period further until October 31, 2016 and having several in-person and telephonic consultations, including one at our National Tribal Health Conference in Scottsdale, AZ on September 19, 2016 in Scottsdale, AZ.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

We appreciate the Indian Health Service's willingness to engage further with Tribes on this proposed rule. As the national organization representing all 567 federally recognized Tribes, below are the comments and recommendations that we have heard from across Indian Country.

CHEF Threshold CAP

NIHB supports the lowering of threshold to \$19,000 in FY 2016.¹ However, we also support the recommendations made by the IHS PRC Workgroup to not adjust the threshold for medical inflation until all CHEF cases are fully funded. Once CHEF is fully funded, apply the medical care expenditure category of the consumer price index for all urban consumers (United States city average). We also support that there be a cap on the threshold that is arrived at through consultation with the PRC workgroup. We recommend that IHS propose legislation or issue a statement in support of setting a cap on the threshold amount. In addition we recommend that a report be done to study the impact to Tribes and CHEF related to the lowered threshold.

Tribal Consultation with IHS PRC Workgroup

In NIHB's previous comment on the proposed rule, we had requested that IHS not move forward with the proposed rule until *Meaningful* Tribal consultation could take place. We are grateful that IHS held several in-person consultation and telephonic Tribal consultations to get input into the development of the proposed rule. We request that IHS rescind this proposed rule completely and develop a new proposed rule in deliberate collaboration with the IHS PRC Workgroup. Prior to beginning the rulemaking process for a new proposed rule, there should also be Tribal consultation per Executive Order 13175.

Definition of Alternate Resources

NIHB remains strongly opposed to the inclusion of "Tribal" as part of the list of primary payers in the "alternate resource" definition located in Section 136.506 the Catastrophic Health Emergency Fund (CHEF) proposed rule. The provision states "any Federal, State, Tribal, local, or private source of reimbursement for which the patient is eligible. Such resources include health care providers, institutions, and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e. Medicare and Medicaid), other Federal health care programs, State, Tribal or local health care programs, Veterans Health Administration, and private insurance." The preamble also states that IHS considers Tribal self-insured plans to be "private insurance." The inclusion of Tribal self-insurance as an alternate resource prior to CHEF reimbursement is intolerable. Tribal governments and Tribal programs will be burdened with a substantial negative impact on Tribal health service programs. NIHB insists that the Indian Health Service (IHS) remove "Tribal" from the definition of "alternate resource" in Section 136.501 and from Section 136.06.

The "alternate resource" definition for purposes of CHEF eligibility is derived from 25 U.S.C. Section 1621e(d)(5), which entails the Secretary "to ensure that no payment be made from CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local or private source of reimbursement for which the patient is eligible." Under 25 U.S.C. Section 1683, CHEF, "shall not be used to pay for

¹ 25 U.S.C. § 1621a

health services provided to eligible Indians to the extent that alternate Federal, State, local, or private insurance resources for payment...are available and accessible to the beneficiary...” “Tribal” is not included as an alternate resource in the law. NIHB understands the need to conserve limited CHEF funds by using other payment resources prior to utilization of the CHEF funds. However, the inclusion of Tribes as one of the sources of payment as alternate resources to CHEF is a gross overreach of the Secretary’s rulemaking authority.

The Contract Health Service (CHS) program, now the Purchased Referred Care (PRC) program applies a similar rule in 42 CFR Section 136.23(f) and 42 CFR Section 136.61. The term “alternate resource” is used to identify programs that must be exhausted before CHS/PRC program funds are paid. In this context, the payer of last resort (PLR) rule defines “alternate resource” to include Federal programs with specific mention of Medicare and Medicaid, and “State, or local health care programs, and private insurance.” There is no reference or intent to include Tribal governments and programs.

The Indian Health Service (IHS) has recognized the importance of preserving Tribal resources for decades. In previous IHS payor of last resort regulations, as well as policy guidance in the IHS Manual, IHS specifically provided that certain Tribally-funded health insurance plans “would not be considered “alternate resources” under IHS’ payor of last resort regulations in an effort to be consistent with Congressional intent not to burden Tribal resources. This drastic change in IHS policy is a clear violation of the government’s Trust responsibility to provide health care to Tribes. Tribes should never pay primary to the federal government and IHS must not move forward with its proposed definition of alternate resources.

Reimbursement Procedure

NIHB remains concerned about the lack of clarity around the procedure for reimbursement set out in the proposed rule. It does not provide any criteria or procedure for how PRC directors will review CHEF claims or how IHS headquarters will determine whether alternate resources exist. Such determinations are left entirely to the discretion of AREA PRC programs and IHS headquarters. This lack of transparency is very concerning and NIHB request that the procedures for governing the reimbursement of CHEF funds include procedures guiding the award process as well as the submission process.

Referral Definition

IHS proposes to define Purchased/Referred Care” in section 136.501 to mean “any health service that is –(1) Delivered based on a *referral by, or at the expense of, an Indian health program*” We think that it is appropriate the regulation recognizes that a PRC referral does not equate to requiring payment for services, particularly because Tribes and Tribal Organizations are payers of last resort. We request that IHS provide clarity that the word “referral” as used in the CHEF regulations is not to be interpreted to require payment for services, nor interpreted in other contexts (e.g., Section 1402(d)(2) of the Patient Protection and Affordable Care Act pertaining to qualification for cost-sharing exceptions).

Conclusion

Thank you for the opportunity to again comment on the Indian Health Service (IHS) Proposed Rule for the Catastrophic Health Emergency Fund (CHEF). NIHB hopes that IHS, in the spirit of its partnership and shared interest in improving American Indian and Alaska Native (AI/AN) access to quality health care, will work with Tribes to advance access to quality health care. Please contact Devin Delrow, NIHB Director of Federal Relations at ddelrow@nihb.org or (202) 507-4072 if there are any additional questions or comments.

Respectfully,

A handwritten signature in black ink, appearing to read 'Lester Secatero', written in a cursive style.

Lester Secatero
Chairman, National Indian Health Board