July 6, 2018

Transmitted via email to: consultation@ihs.gov

RADM Michael D. Weahkee
Acting Director
Indian Health Service
5600 Fishers Lane, Mail Stop 08E86
Rockville, MD 20857

Re: Comments on Indian Health Service's (IHS) May 18, 2018 Dear Tribal Leader Letter (DTLL) initiating tribal consultation on changes to the Indian Health Manual (the "Manual"), Part 2, Chapter 3 "Services to Indians and Others"

Dear RADM Weahkee:

The California Rural Indian Health Board (CRIHB) and Northwest Portland Area Indian Health Board (NPAIHB), submit these joint written comments responding to the Indian Health Service's (IHS) May 18, 2018, Dear Tribal Leader Letter (DTLL) initiating tribal consultation on changes to the Indian Health Manual (the "Manual"), Part 2, Chapter 3 "Services to Indians and Others" (also known as "Purchased/Referred Care" or "PRC") (the "PRC Chapter"). CRIHB was founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization in accordance with P.L. 93-638, and is a statewide Tribal health organization representing 44 federally-recognized tribes through its membership of 15 Tribal Health Programs throughout California's Indian Country. The NPAIHB is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest.

Background on Portland and California Areas

The Portland and California IHS Areas are PRC-dependent because tribes in these Areas do not have access to hospital care provided through IHS or access to ancillary diagnostic services that support basic medical care (e.g. x-ray, laboratory, pharmacy), which is then necessarily paid through PRC funding. The PRC program has been called one of the most important health services for tribes and tribal clinics in the Portland and California IHS Areas. Tribal clinics most often do not have specialty care providers on staff, forcing them to buy this care from providers in the private sector using PRC program funds. Inequitably, the IHS agency's distribution of PRC program funds varies across the 12 Areas in the United States. According to the Government Accountability Office (GAO), funding has ranged from $17 million in one Area to more than $95 million in another Area.

On June 13, 2018, IHS testified before the United States Senate Committee on Indian Affairs in an oversight hearing entitled "GAO High Risk List: Turning Around Vulnerable Indian Programs". Acting Director Weahkee stated that IHS continues to work closely with tribal leaders in making decisions about the PRC funding allocation and that any future changes in PRC allocation methods will undergo tribal consultation. He also stated that as recently as October 2017, the Director's Workgroup on Improving PRC ("PRC Workgroup") recommended maintaining the existing PRC formula without any changes. GAO staff participated in two PRC Workgroup meetings where they engaged in discussions with tribal leaders about their recommendations. After discussion with the Workgroup, GAO acknowledged IHS's limited ability to make any changes to the PRC formula that could potentially result in the reduction of funds to any tribe. GAO subsequently made the decision to close two recommendations concerning the PRC formula allocation as not implemented.

We are concerned that despite past and ongoing PRC Workgroup activities and tribal consultation, the consensus decision-making model in which group members develop and agree to support a decision in the best interest of the whole, does not and will not achieve an acceptable resolution with regards to PRC. This is so because the majority of IHS Areas do not experience the level of PRC-related deficiencies like the minority of PRC-dependent IHS Areas and will more than likely oppose changes to the PRC formula or funding for fear they will end up with less themselves. The PRC Workgroup is an advisory body that provides input to the IHS agency on factors that may be included into the formula. Although IHS will receive and consider recommendations through government-to-government consultation on this subject with tribes, IHS is ultimately responsible for authorizing the formula and policies that result in the distribution of PRC resources across IHS Areas. The official role of the IHS agency as the authorizing federal entity to determine how the funds shall be expended, is of the utmost importance to addressing the glaring service deficiencies and funding inequities in the IHS delivery system that tribes face in the Portland and California IHS Areas that are PRC-dependent and without IHS/Tribal hospitals.

General Comments on the Draft PRC Chapter

IHS's legal authority for issuing the Manual is addressed in the eligibility regulation at 42 C.F.R. § 136.3, which provides that the IHS will periodically issue administrative instructions to its officers and employees that are primarily found in the Manual: "These instructions are operating instructions to assist IHS officers and employees in carrying out their responsibilities and are not regulations establishing program requirements which are binding upon members of the general public." Thus, the IHS cannot use the Manual to rewrite the PRC regulations at 42 C.F.R. Part 136, Subpart C and 42 C.F.R. § 136.61, which establishes the payor of last resort rule.

If the IHS wants to issue "substantive rules of general applicability adopted as authorized by law or statements of general policy or interpretations of general applicability," the IHS must publish them in the Federal Register in accordance with the Administrative Procedure Act (APA), 5 U.S.C. §§ 552(a) and 553 (notice and comment rulemaking). Thus, the IHS cannot use the Draft PRC Chapter to (1) redline/edit and paraphrase the actual language of the regulations as a means to change the regulations without going through APA procedures; (2) establish formal agency interpretations of statutes and regulations again without complying with the APA; or (3) declare, in certain instances, that the IHS will no longer adhere to specific requirements in the regulations. Furthermore, as stated in 42 C.F.R. § 136.3 noted above, the Manual provides administrative instructions to IHS officers and employees carrying out PRC programs operated by the IHS. It is not binding on Indian tribes and tribal organizations carrying

out contracted or compacted PRC programs under the Indian Self-Determination and Education Assistance Act (ISDEAA), unless a tribe or tribal organization expressly agrees in its contract, compact, or funding agreement to be bound by the Manual.[1]

In the future, we encourage the IHS to meet with Tribal Workgroups and technical advisors to hear and incorporate their recommendations before issuing a DTLL, particularly on detailed matters such as this. *The PRC Workgroup was not presented with all of the draft revisions to the PRC chapter nor the opportunity to consider or deliberate the changes before the DTLL was issued.*

In general, throughout the Draft PRC Chapter, there are numerous errors, including but not limited to: (1) terms are incorrectly phrased as plural or singular when it should be the opposite; (2) undefined or vague terms or phrases are used instead of those with specific meaning in the definitions section;[2] (3) specific terms are used inconsistently (*e.g.,* "Indian" versus "American Indian/Alaskan Natives"); (4) phrases and terms with acronyms are spelled out instead of identified by their acronyms; and (5) citations reference the wrong authority, and links do not work or reference incorrect materials. Some, but not all, of these errors are identified in the enclosed redline document.

Lastly, we suggest returning to the numbering of subsections to A, B, C, then (1), (2), (3), and a, b, c.[3] Similarly, the definitions in Section 2-3.1.5 should be ordered alphabetically. Furthermore, we cannot properly comment at this time on the proposed changes to numerous provisions referencing Manual Exhibits or the documents themselves because the IHS has not released or made public revised versions.[4]

The following is a summary of the major issues we have identified with IHS's proposed revisions to the PRC Chapter, and our recommendations.

Definitions (Section 2-3.1(5))

Since the PRC Chapter cannot re-define terms already defined by statute or regulation, Section 2-3.1(5) should contain definitions as already prescribed by law. If clarification is necessary for IHS officers and employees to understand terms, the PRC Chapter should set off the legal definition in quotes to contrast it with the Agency's own explanation.

Alternate Resources

The "Alternate Resources" definition at Section 2-3.1(5)(1) should use the legal definition of "Alternate Resources" at 42 C.F.R. § 136.21, (referring to the definition of "alternate resources" at 42 C.F.R. § 136.61(c)). In addition, the reference to "Federal, State, local or private source" of coverage

[1] 25 U.S.C. §§ 5329(c)(1) (model self-determination contract § 1(b)(11)), 5397(e).
[2] For example, "facility" compared to "IHS facility." Facility alone is an undefined term. Since the PRC Chapter does not regulate tribal health programs, we suggest identifying, where appropriate, the phrase as an IHS facility. Otherwise, this statement would infringe on tribal self-governance.
[3] These written comments reference the sections of the PRC Chapter using the numbering system in the Draft.
[4] The Manuel Exhibits that are unavailable for comment include: Manual Exhibit 2-3-B (Authorization for Use or Disclosure of Health Information); Manual Exhibit 2-3-J (Object Class Code Narratives and Service Class Code Narratives); Manual Exhibit 2-3-P (New; Discusses Time of Payment by IHS); Manual Exhibit 2-3-Q (New; Sample letter to patients notifying them that they are not liable for payment of services authorized and approved for payment under a PRC Program).Manual Exhibit 2-3-B; Manual Exhibit 2-3-J; Manual Exhibit 2-3-P; Manual Exhibit 2-3-Q.

should include additional language that "local" does not mean "tribal," and "private source" does not mean tribal self-insured health plans.

Tribally-Operated Program

Also of concern is the definition of "Tribally-Operated Program," which is defined in Section 2-3.1(5)(31) as "a program operated by a Tribe or Tribal organization that has contracted under Pub. L. 93-638 to provide a PRC program," is inconsistent with the court's ruling in the *Redding Rancheria* case[5].

The court in *Redding Rancheria* interpreted the following provision, codified by the Affordable Care Act (ACA) at 25 USC § 1623(b):

> Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act [IHCIA] (25 U.S.C. § 1603) shall be the payor of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

During litigation, the IHS took the position that this language referred to the definition of the term "tribal health program" in Section 4(25) of the IHCIA, 25 U.S.C. § 1603(25), which is defined as a program compacted or contracted with the IHS under the ISDEAA. The effect of the IHS's interpretation was to exclude tribal self-insured health plans and make them alternate resources. The court rejected this argument, determining that the parenthetical language—"(as those terms are defined in section 4 of the IHCIA)"—referred to how all of the entities listed (the IHS, tribes, tribal organizations, and urban Indian organizations) are defined in the IHCIA. The result of the court's holding was that "health programs operated by Indian tribes, tribal organizations" meant *any* health program operated by tribes and tribal organizations, including tribal self-insurance plans.

Therefore, we recommend that the term "Tribally-Operated Program" be removed from the Draft PRC Chapter and that the IHS instead use the term "Tribal Health Program," which is defined in Section 1603(25) of the IHCIA, for references to tribally compacted or contracted programs, as appropriate.

Notification of Claim

The definition of "Notification of a Claim" in Section 2-3.1(5)(22) is duplicative of Section 2-3.21(2)(1) and (2). As this term requires significant explanation, more in the form of requirements than a definition, we recommend that Section 2-3.1(5)(22) be deleted.

Other Definitions

Lastly, there are several new definitions added to the Draft PRC Chapter. For example, “Medical Referral” is “[a] referral for health care services that is not authorized for payment by PRC.” We suspect

[5] *Redding Rancheria v. Hargan*, No. 1:14-cv-02035-RMC, 2017 WL 5157235 (D.D.C. November 7, 2017),

that this definition is included to distinguish it from a PRC Referral. With no description on the purpose of new definitions, it is difficult to comment.

PRCDAs (Section 2-3.3)

In Section 2-3.3(1), the IHS takes the position that it may only provide services in Purchased/Referred Care Delivery Areas (PRCDAs) under the current regulations, stating that it would have to amend the regulations by notice and comment rulemaking in order to recognize new PRCDAs. While the IHS does not directly state it, they appear to be taking the position that new PRCDAs established by Congress cannot be implemented until the IHS changes its regulations. This position is contrary to current law because acts of Congress supersede conflicting agency regulations.

Re-designation of a PRCDA (Section 2-3.4)

Another confusing change seems to expand the consultation requirement. Currently, the regulations only require consultation with tribes *within* a PRCDA;[6] but as we read the new provision in Section 2-3.4(3)(1) of the Draft PRC Chapter, an Area PRC Officer must consult with *any* tribe affected by a designation or re-designation of a PRCDA. The intent behind the provision could be to simply reiterate the consultation requirement instead of creating a new one, but this is not clear from how the IHS phrased it.

In Section 2-3.4(3)(3), the IHS includes an ad hoc PRCDA Designation/Re-Designation Committee—a committee with which we are not familiar. It is unclear whether this Committee is new or if it is already existing practice that is just now being written down. As provided for in the Draft PRC Chapter, this Committee would review re-designation requests submitted to the Director of the Division of Contract Care (DCC) to determine if the information submitted meets the criteria set forth in Section 2-3.4(1). The Director of the DCC would then send the Committee's findings and recommendation to the Director of the IHS for a final determination. As drafted, the Committee's recommendation would replace that of the Director of the DCC. There is not much information about the Committee besides that its membership would include leadership from numerous offices within the IHS. We request the origin, makeup, roles and responsibilities of the PRCDA Committee. Furthermore, stating that the PRCDA designation/re-designation cannot be appealed suggests that the IHS's decision cannot be appealed under the APA, which is incorrect.

Eligibility Requirements (Section 2-3.6)

The way in which both the current and Draft PRC Chapter outline the PRC eligibility requirements is different from how they are outlined in the PRC eligibility regulations, which creates significant confusion. In the enclosed redline document, we suggest that this be fixed in the Draft PRC Policy at Section 2-3.6(2), in order to mirror the outline in the regulations. The following statement would also be helpful:

> To be eligible for PRC, a person must be eligible for services as described in and in accordance with 42 C.F.R. §136.12, subject to the provisions of 42 C.F.R. §136.23.

[6] *See* 42 C.F.R. § 136.22(b).

We support the continued inclusion of a specific subsection devoted to “California Indians” in the eligibility section. We also support several changes by the IHS in the eligibility section including: (1) a change to Section 2-3.6(3), which recognizes the ability of tribes to define who is eligible for PRC though close economic and social ties; and (2) the addition of "high school" students as full-time students eligible for care outside of their PRCDA (Section 2-3.6(4)).

However, we have several recommendations for the new provision about PRC for persons in custody. The Draft PRC Chapter does not define what the IHS would consider "Indian law enforcement." We recommend the IHS clarify that the phrase "Indian law enforcement" includes both the Bureau of Indian Affairs (BIA) and tribal law enforcement, and explain how the IHS would identify law enforcement agencies operating under a contract or compact with a tribe to provide law enforcement services. Similarly, the purpose of putting "non-Indian" in parentheses is unclear.

Payor of Last Resort Requirements (Section 2-3.8)

Alternate Resources

In numerous places throughout the Draft PRC Chapter, the IHS defines and provides criteria for determining what it would consider an "alternate resource." The definitions section includes programs under "the Social Security Act (*i.e.,* Medicaid, Medicare and Children's Health Insurance Program), other Federal healthcare programs, State and local healthcare programs, [the] Veterans Health Administration, and private insurance" (Section 2-3.1(5)(1)). The payor of last resort rule section also adds Vocational Rehabilitation, Children's Rehabilitative Services and the Crime Victims Act (Section 2-3.8(7)). Instead of multiple, inconsistent definitions, the Draft PRC Chapter should cite the current regulation at 42 C.F.R. § 136.21, referring to the definition of "alternate resources" at 42 C.F.R. § 136.61(c), for the definition. Then, in Section 2-3.8(7), the IHS may expand upon the definition with more information. Furthermore, the alternate resources section should state that "local" does not mean "tribal," and "private health insurance" does not mean tribal self-insured health plans.

In Section 2-3.8(7), the statement "All IHS or Tribal facilities that are available and accessible to an individual are considered alternate resources" appears to be intended to capture the requirement that an individual may not access PRC if services are available at the IHS/Tribal facility. However, that requirement is already in the regulations, and it is inappropriate to add here. As drafted, the language suggests that both the IHS and/or a tribe could be considered an alternate resource— i.e., alternate to themselves. This is inconsistent with the law, and inconsistent with the *Redding* decision. We recommend deleting the statement.

Sponsorship of Plans. In terms of other coverage provided by tribes, from the language of Section 2-3.8(10) it appears the IHS would consider insurance purchased by a tribe for its members (also known as "sponsorship" plans) as an alternate resource, unlike tribal self-insurance but separate from reinsurance. Section 402 of the IHCIA, 25 U.S.C. § 1642, authorizes Indian tribes, tribal organizations, and urban Indian organizations to use federal funds available to them under the ISDEAA, Social Security Act programs (such as Medicare, Medicaid, and Children's Health Insurance Plan reimbursements), or under other federal laws, to purchase "health care benefits coverage" for IHS eligible beneficiaries.

Section 2-3.8(1) states that "IHS considers sponsorship through indemnity to be an alternate resource under the payor of last resort rule." It is unclear what the IHS means by "sponsorship through indemnity." It is assumed that IHS means "sponsorship of insurance plans"; however, we request the language change from "insurance plans" to or clarification Furthermore, for ease of reading, we suggest moving this provision up to be included within the provision about alternate resources in Section 2-3.8(7).

Charity or Indigent Care Programs. In Sections 2-3.8(1)(3) and 2-3.8(1)(7), the IHS states that a charity or indigent care program is not considered an "alternate resource" for purposes of the payor of last resort rule when the PRC provider absorbs the full cost of services provided. In other words, the IHS does not consider a non-Indian provider an available source of payment to himself or itself. One example of this could be when a hospital charity program writes-off the cost of care for services provided to persons eligible for the charity program. However, such programs may still be "health care resources" under the IHS payor of last resort rule at 42 C.F.R. § 136.61, and we think it is reasonable to conclude under the statutory language at 25 U.S.C. § 1623(b) that a charitable source of coverage—including write-offs by providers under established charity or indigent care programs—should be accessed before a PRC program would have to be the payor for care. We thus suggest that the language on charitable programs in Section 2-3.8(1)(3) be removed and the language in Section 2-3.8(1)(7) be revised to clarify that available charity or indigent care programs are considered alternate resources for purposes of PRC if an individual is eligible for the program or would be eligible but for having PRC.

Student Grant Funds. As drafted, the provision requiring students to purchase health insurance with grant funds places a requirement on students that may be incompatible with the terms of a grant(s). Additionally, it is unclear whether "individuals" in the next sentence means to require *any* person receiving funds for health insurance to purchase it, or only students. We recommend that the IHS clarify and move the provision up to be included within the provisions for alternate resources in section 2-3.8(7).

Tribal Self-Insurance

Section 2-3.8(9) would expressly exempt "tribally funded self-insurance plans"[7] from consideration as an alternate resource but "[a]ny portion of the plan that is reinsured will not be considered Tribal Self-Insurance." While the proposed language as drafted may be intended to only include the reinsurance itself as an alternate resource, that is not how it reads. The language as drafted states that the IHS would consider the entire reinsurance plan an alternate resource if a tribe has any reinsurance on it. While it may be appropriate for reinsurance to be considered an alternate resource when the reinsurance is paying, rather than the tribe, it is not appropriate for a Tribal Self-Insured plan to be considered an alternate resource simply because it is reinsured. Furthermore, the Draft PRC Chapter's exclusionary clause does not recognize that the IHS may bill Tribal Self-Insurance if the tribe gives permission.[8] The PRC Chapter should not foreclose this option. The redline document revises provisions for the Tribal Self-Insurance to reflect these recommendations. Lastly, for ease of reading, we recommend moving this provision directly below the alternate resources provision and above the qualified health plan provision.

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[7] We note that the phrase "tribally funded self-insurance plans" differs from the specifically defined term "Tribal Self-Insurance," and the defined term "Tribal Self-Insurance" should be used.
[8] *See* 25 U.S.C. § 1621e(f).

Failure to Follow Alternate Procedures

As Section 2-3.8(4)(1) is structured in the Draft PRC Chapter, it is not clear what action the 10-day timeframe applies to. Is it for contacting facility staff for help, to complete an application, or both? Or, does it reference the issuance of a denial letter? As currently drafted, it is unlikely that providers would be able to understand the requirements of this provision. Our redline document attempts to make this clearer but we recommend that the IHS revise this section to more accurately communicate the requirements. Furthermore, the current PRC Chapter provides for a 30-day timeframe, which the IHS changed to 10-days in the Draft PRC Chapter. The IHS should change it back to 30 days or provide a citation authorizing the change.

Authorization for Purchased/Referred Care (Section 2-3.9)

In Section 2-3.9(3), Authorization for PRC, the IHS appears to place a mandate on the Centers for Medicare and Medicaid Services (CMS). The IHS cannot govern the activities of the CMS. If there is an agreement between the IHS and the CMS recognizing that the CMS will take these actions, the IHS should reference it in this section. 42 CFR §489.29 implements Medicare-Like Rates (MLR) for inpatient facilities. CMS has taken responsibility for enforcing the standards through each CMS Regional Office.[9] There is no CMS enforcement for the outpatient standards IHS implemented.

Section 2-3.9(2) seems to be based on Subpart I which applies only to outpatient services (Subpart I, §§136.201- 136.204). Inpatient MLR is described in Subpart D, §§ 136.30-136.32.

Under Section 2-3.9(3)(1)(3) which addresses PRC rates for physicians and non-hospital supplies and services, there is no explanation as to the "mandatory" requirement for providers to enter information into the Provider Tracking Tool located at: https://home.ihs.gov/OtherPrgms/IHPES/ORAP/TPICPSA/index.cfm?module=prc&option=admin&fn=doPRCvalidate. This seems to be mandatory for the PRC staff, rather than providers. Tribal Health Programs might use other tools. We request an explanation on this new requirement. Also, when we tried to access this link, the link was broken.

Tribal Appeals Process (Section 2-3.11)

We support the new provision at the end of Section 2-3.11(4), which is the tribal appeals process for contractors, because it recognizes that tribal contractors are not legally required to use the IHS appeals process for their PRC program. However, it appears to only discuss the Tribal Appeals Process in terms of retained authority but does not refer to the option to buy back the appeals process. Our redline document adds language to recognize that tribes have this option.

Additionally, Section 2-3.11(5)(1) states that the IHS will not use "Tribal criteria and interpretations" in the appeals process. This is inconsistent with several other provisions: Section 2-3.6(3), which states that the IHS will recognize tribally defined criteria for PRC eligibility; Section 2-3.11(7) (following this provision) that recognizes that tribes may set different standards for PRC eligibility and medical priorities; and Section 2-3.20(6), recognizing tribal criteria for high cost cases.

[9] *See* CMS memo to State Survey Agency Directors, October 3, 2008.

This provision should allow for a process that includes review by the aforementioned tribal standards, not those set by the IHS. As an aside, we support all of the provisions recognizing the authority of tribes to set their own criteria and standards.

Management of Purchased/Referred Care Funds (Section 2-3.12)

We appreciate the flexibility for tribes to adjust funding based on local needs in Section 2-3.12(1), Allocation of PRC Funds. However, we note that the ability of individual PRC programs to make a determination about using PRC funds for staff administering the PRC program is problematically conditioned on the Area Director making annual reports (Section 2-3.12(3)(1)). As reflected in the enclosed redline document, the provision can be kept but should be made into a separate criteria instead of a condition for using PRC funds for staff administering the PRC program.

Notification of Claim (Section 2-3.21(2)(1)

Section 2-3.21(2)(1) is paraphrased from 42 C.F.R. § 136.24(b), and is not an accurate statement of the regulations. This provision should accurately reflect the law. Similarly, Section 2-3.21(2) prefaces all the requirements that follow with citations to statutes and the regulations. This could lead the reader to presume that those statutes and regulations legally oblige the provider to meet the requirements. However, the three requirements in Section 2-3.21(2)(2) are not mandated by any law and are only provided for in policy. The enclosed redline document provides solutions to these problems.

Additionally, Section 2-3.21(2)(2)(1) appears to require information from a provider (whether a patient is eligible for care) that a provider would not have. It is the IHS's responsibility to determine whether a patient is eligible. If the IHS's intent is that this provision require sufficient information about the patient from the provider so that *the IHS* can identify a patient as eligible on its end, that is unclear and should not be a requirement. Similarly, the use of "IHS services" in this provision is unclear because it is an undefined term. We recommend removing this provision.

Conclusion

We appreciate the opportunity to provide our input into the IHS's revisions to the PRC Chapter, and thank you for considering our written comments. For additional information please contact CRIHB's Health Policy Analyst, Sunny Stevenson at (916) 929-9761 or sstevenson@crihb.org or NPAIHB's Director of Government Affairs/Health Policy Analyst, Laura Platero at (503) 407-4082 or lplatero@npaihb.org.

Very truly yours,

Lisa Elgin
Chair
California Rural Indian Health Board

Andy Joseph, Jr.
Chair
Northwest Portland Area Indian Health Board

Comments on Indian Health Service's (IHS) May 18, 2018 Dear Tribal Leader Letter (DTLL) initiating tribal consultation on changes to the Indian Health Manual (the "Manual"), Part 2, Chapter 3 "Services to Indians and Others"

ATTACHMENT: Redline of Draft PRC Chapter Update

As noted in our July 6, 2018 comment letter, we believe that this redline document communicates our recommendations more concisely than written comments could. However, we explain many of our suggested changes in greater detail in the letter.

Indian Health Service (IHS) Indian Health Manual, Part 2 Chapter 3

Below are draft revisions to the Indian Health Service (IHS) Indian Health Manual, Part 2 – Services to Indians and Others, Chapter 3 – Purchased Referred Care. Proposed revisions and additions are in BOLD

~~1.~~ 2-3.1 INTRODUCTION

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1. Purpose. This revised chapter publishes the policy, procedures, and guidance for the effective management of the Indian Health Service (IHS) Purchased/Referred Care (PRC) Program. The authority to manage the operation of the PRC Program is delegated to the greatest degree possible, within the limits of available funds, to Area Directors and Chief Executive Officers (CEO). In the event PRC funds are depleted, PRC payment for services must be denied or deferred and the CEO must notify the Area Director.

2. Authorities.

    1. 25 U.S.C. 13 (Snyder Act)

    2. 42 U.S.C. 2001 et seq. (the Transfer Act of 1954)

    3. 42 *Code of Federal Regulations* (CFR) 136 Subparts C, D, I and G

    4. Public Law (Pub. L.) 111-148, Patient Protection and Affordable Care Act (March 23, 2010) — (Payer of Last Resort)

    5. Pub. L. 111-5 "The American Recovery and Reinvestment Act of 2009" — (Medicaid Cost Sharing)

    6. Pub. L. 108-173 "Medicare Prescription Drug Improvement and Modernization Act of 2003" — (PRC Rates for services furnished by Medicare-Participating Hospitals)

3. Policy. It is IHS policy to ensure that PRC funds are used to supplement and complement other health care resources available to eligible American Indian and Alaska Native (AI/AN) people. The funds are utilized in situations where:

    1. no IHS direct care facility exists;

    2. the direct care element is incapable of providing required emergency and/or specialty care;

    3. the direct care element has an overflow of medical care workload; and

    4. supplementation of alternate resources ~~(i.e., Medicare, Medicaid, private insurance, Veterans Health Administration)~~ is required to provide comprehensive health care to eligible AI/ANs.

4. Acronyms.

    1. AMA — Against Medical Advice

    2. ARRA — American Recovery and Reinvestment Act

    3. CY — Calendar Year

    4. CHEF — Catastrophic Health Emergency Fund

5. CEO — Chief Executive Officer

6. CFR — *Code of Federal Regulations*

7. CHS/MIS — Contract Health Services/Management Information System

8. CDSR — Core Data Set Requirement

9. CMS — Centers for Medicare and Medicaid Services

~~9.~~10. DCC — Division of Contract Care

~~10.~~11. EHR — Electronic Health Record

~~11.~~12. EPHI — Electronic Personal Health Information

~~12.~~13. FMFIA — Federal Managers Financial Integrity Act

~~13.~~14. FMCRA — Federal Medical Care Recovery Act

~~14.~~15. FR — *Federal Register*

~~15.~~16. FI — Fiscal Intermediary

~~16.~~17. FY — Fiscal Year

~~17.~~18. HITECH — Health Information Technology for Economic and Clinical Health Act

~~18.~~19. HIPAA — Health Insurance Portability and Accountability Act

~~19.~~20. IHCIA — Indian Health Care Improvement Act

21. MMA — Medicare Modernization Act

~~20.~~22. ORAP — Office of Resource Access and Partnership

~~21.~~23. PHI — Protected Health Information

~~22.~~24. PRC — Purchased/Referred Care

~~23.~~25. PRCDA — Purchased/Referred Care Delivery Area

~~24.~~26. PRCO — Purchased/Referred Care Officer

~~25.~~27. RCIS — Referred Care Information System

~~26.~~28. RPMS — Resource and Patient Management System

~~27.~~29. UFMS — Unified Financial Management System

30. U.S. — United States

~~28.~~31. U.S.C. — *United States Code*

~~29.~~32. VA — Veterans Health Administration

5. Definitions (Also see 42 CFR 136.21).

    1. Alternate Resources. Alternate resources are "health care resources other than those of the Indian Health Service. Such resources include health care providers and 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, Medicaid), State or local health care programs, and private insurance," as defined by 42 CFR 136.61(c).~~any Federal, State, local, or private source of coverage for which the patient is eligible. Such resources include health care providers and institutions and health care programs for the payment of health services including but not limited to programs under the Social Security Act (i.e., Medicare and Medicaid, Children's Health Insurance Program), other Federal health care programs, State and local health care programs, Veterans Health Administration and private insurance~~

    2. Appropriate Ordering Official. The ordering official for the PRCDA in which the individual requesting PRC or on whose behalf the services are requested, resides, unless otherwise specified by contract with the health care facility or provider. This usually means ~~T~~the person, with documented delegated procurement authority, who signs the purchase order authorizing the obligation of PRC funds.

    3. Area Director. The Director of an IHS Area Office designated for purposes of administration of IHS programs.

    4. Catastrophic Health Emergency Fund. The Catastrophic Health Emergency Fund (CHEF) is the fund established by Congress to reimburse extraordinary medical expenses incurred for catastrophic illnesses and disasters covered by a PRC program of the IHS, whether such program is carried out by IHS or an Indian Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act.

    5. Catastrophic Illness. Catastrophic illness is a medical condition that is costly by virtue of the intensity and/or duration of its treatments. Examples of conditions that frequently require multiple hospital stays and extensive treatment are cancer, burns, premature births, cardiac disease, end-stage renal disease, strokes, trauma-related cases such as automobile accidents and gunshot wounds and some mental disorders.

    6. Medicare Approved Transplant Program. A facility or institution that has met or exceeded defined standards of care in which transplants of organs are performed. The transplant program is a component within a transplant hospital that provides transplantation of a particular type of organ.

    7. CHEF Case. A CHEF case is an episode of acute medical care for a condition from an illness or injury, requiring extensive treatment that incurs medical costs to the IHS in excess of the CHEF threshold.

    8. CHEF Threshold Cost. A designated amount above which incurred medical costs will be considered for CHEF reimbursement after a review of the authorized expenses and diagnosis.

    9. Chief Executive Officer. The Chief Executive Officer (CEO) is the Director of the IHS program at the service unit level for the purposes of administration of the health service programs for that location.

    10. Medical Referral. A referral for health care services authorizes care but ~~that~~ does~~is~~ not represent that a patient is eligible for PRC and does not authorize~~d for~~ payment by PRC.

11. Purchased/Referred Care Delivery Area. The Purchased/Referred Care Delivery Area (PRCDA) is the geographic area within which PRC will be made available by the IHS and Tribal Health Programs.

12. Purchased/Referred Care. Purchased/Referred Care (PRC) is any health service that is:

    1. delivered based on a referral by, or at the expense of, an Indian health program; and

    2. provided by a public or private medical provider or hospital which is not a provider or hospital of the IHS or Tribal health program.

13. Purchased/Referred Care in Support of Direct Care. These are contracted specialty physician and non-physician specialty medical services provided within an IHS/Tribal facility when the patient is under direct supervision of an IHS physician or a contract physician practicing under the auspices (or authority) of the IHS facility.

14. Core Data Set. The PRC Core Data Set consists of required data for management of the PRC program that constitutes a subset of data collected in the IHS information system. The purpose of the data is to assist the IHS in its internal management and to satisfy Congressional and other mandatory reporting requirements.

~~15.~~ Deferred Services. Deferred services are services referred for PRC that do not meet immediate medical priority for payment guidelines for which the provision of treatment can be postponed or delayed and the service has not been provided.

~~16. Descendaent of a Tribal Member. An individual biologically descended from an enrolled member of the Tribe.~~

~~17.~~15. E-SIGN. E-SIGN is the electronic equivalent of a hand-written signature requiring user authentication, such as a digital certificate, smart card or biometric method for verification.

~~18.~~16. Emergency. An emergency is any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.

~~19.~~17. Episode of Care. The period of consecutive days for a discrete health condition during which reasonable and necessary medical services related to the condition occur.

~~20.~~18. Fiscal Intermediary. The Fiscal Intermediary (FI) is the fiscal agent contracted by IHS to provide and implement a system to process PRC medical, dental and behavioral health claims for payment (42 U.S.C. 238m).

~~21.~~19. Indian Tribe. Any Indian Tribe, band, nation, group, pueblo, or community, including any Alaska Native village or Native group, which is Federally-recognized as eligible for the special programs and services provided by the ~~United States (~~U.S.~~)~~ to Indians, because of their status as Indians.

~~22. Notification of a Claim. For the purposes of 42 CFR part 136, and also 25 U.S.C. 1621s and 1646, the submission of a claim that meets the requirements of 42 CFR 136.24.~~

~~1. Such claims must be submitted within 72 hours after the beginning of treatment for the condition or after admission to a health care facility, notify the appropriate~~

Commented [1]: The purpose of this definition is unclear, as the term is not used within the PRC Chapter.

If it is intended to reference "descendant of an Indian" under the eligibility of California Indians section, the definition is redundant, as the term is already defined in Section 2-3.6.10. Thus, we recommend deleting this definition.

Commented [2]: This definition is duplicative of Section 2-3.21(2)(1) and (2). We suggest removing it from the definitions section for clarity. Our comments regarding notification of a claim are below in Section 2-3.21.

~~ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services.~~

~~2. The information submitted with the claim must be sufficient to:~~

~~1. Identify the patient as eligible for IHS services (e.g., name, address, home or referring service unit, Tribal affiliation),~~

~~2. Identify the medical care provided (e.g., the date(s) of service, description of services), and~~

~~3. Verify prior authorization by the IHS for services provided (e.g., IHS purchase order number or medical referral form) or exemption from prior authorization (e.g., copies of pertinent clinical information for emergency care that was not prior-authorized).~~

~~23.~~20. PRC Rates. The PRC rates are the rates IHS adopted in 42 CFR 136 Subpart D and Subpart I for payment of services authorized for payment through a PRC program. These rates are commonly referred to as Medicare-like rates.

~~24.~~21. PRC Referral. An authorization for medical care by the appropriate ordering official in accordance with 42 CFR part 136 subpart C.

~~25.~~22. Reservation. Any Federally-recognized Indian Tribe's reservation, pueblo, colony, including former reservations in Oklahoma~~Indian allotments~~, or Rancheria, including Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 *et seq*), and Indian allotments.

~~26.~~23. Residence. In general usage, a person "resides" where he or she lives and makes his or her home as evidenced by acceptable proof of residency or established by the IHS facility or ~~tribally-operated PRC program~~tribal health program.

~~27.~~24. Secretary. Secretary of the Department of Health and Human Services (HHS).

~~28.~~25. Service. The Indian Health Service.

~~29.~~26. Tribal Health Director. The Director of a ~~Tribally-operated program~~tribal health program, or his/her designee, authorized to make decisions on payment of PRC funds pursuant to a Pub. L. 93-638 contract.

~~30.~~27. Tribal Member. A person who is an enrolled member of a Tribe or is granted Tribal membership by some other criteria by the appropriate Tribal governing policy/document.

~~31.~~28. Tribal~~ly-Operated~~ Health Program. An Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).~~A program operated by a Tribe or Tribal organization that has contracted under Pub. L. 93-638 to provide a PRC program~~

29. Tribal Organization. The recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities.

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Commented [3]: The purpose of deleting "former reservations in Oklahoma" from the definitions is unclear. The proposed change to this definition is not compliant with 25 U.S.C § 1603(16) or 42 CFR § 136.21(i).

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30. Tribal Self-Insurance. A health plan that is funded ~~solely~~ by a Tribe or Tribal organization and for which the Tribe or Tribal organization assumes the burden of payment for health services covered under the plan either directly or through an administrator. To the extent any Tribal self-insurance plan has reinsurance or stop loss insurance from which claims are paid by entities other than the Tribe or Tribal organization, such reinsurance or stop loss insurance shall not be considered tribal self-insurance; provided that the fact that a tribal self-insurance plan has reinsurance or stop loss insurance does not mean that the tribal self-insurance shall be considered an alternate resource. ~~Any portion of the plan that is reinsured will not be considered Tribal Self-Insurance.~~

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~~32.~~31. Unmet need - PRC. The IHS collects data on cases of unfunded PRC services—services for which funding was not available—from the individual federal~~ly~~ PRC progams and voluntarily from ~~tribally-operated PRC programs~~ tribal health programs. Counts of deferral and denial cases are recorded by the individual PRC programs, collected by the Area Offices, and submitted to HQ. The aggregate count of cases is multiplied by the average cost per PRC claim (weighted average of the costs for inpatient, outpatient and transportation paid PRC claims) provided by the FI to estimate PRC program resource unmet need.

~~33.~~32. Urgent Care. The delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency department.

~~34.~~33. Veterans Eligible for VA Resources. Eligibility for VA resources is dependent upon a number of variables, which may influence the final determination of services for which the veteran qualifies. These factors include the nature of a veterans discharge from the military service (e.g., honorable, other than honorable), length of service, VA adjudicated disabilities (commonly referred to as service connected disabilities), income level and available VA resources among others.

~~2.~~ 2-3.2 RESPONSIBILITIES

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1. Director, Division of Contract Care. The Director, Division of Contract Care (DCC), IHS Headquarters (HQ) will:

    1. Establish general policies regarding the administration of the PRC program in the IHS.
    2. Establish standards of performance for Area, service unit and FI operations of PRC.
    3. Assess the performance of the PRC program at Area, service unit and FI against established standards.
    4. Assess long-term purpose and direction of the PRC program to ensure maximum effectiveness of the program in meeting the health needs of AI/AN people.
    5. Develop long-term plans and objectives for the future development of the PRC program.
    6. Provide staff assistance to Area Offices in matters of general policies and procedures.
    7. Prepare budget justification for the total PRC program.
    8. Allocate funds through the Office of Finance and Accounting to Area Directors.

9. Promptly and appropriately respond to appeals of denials of PRC by IHS Area Offices.

10. Provide guidance in the establishment of medical priorities.

11. Provide project officer services for the FI contract and all FI evaluation projects.

12. Respond to congressional questions and requests for information from the PRC program.

13. Centrally manage the CHEF.

14. Establish general guidelines and policies for applying coordination of care practices and PRC quality assurance activities in the Areas and service units.

15. Continue to operate and refine a Management Control System for the PRC function that conforms to the requirements of the Federal Managers' Financial Integrity Act (FMFIA), Section 2 [31 U.S.C. 3512 (b)] and IHS policies and procedures cited in Part 5, Chapter 16, "Management Control Systems," *Indian Health Manual* (IHM).

2. Area Director. The Area Director administers the PRC program, ensuring the program operates within regulations, policies, procedures and the budget. The Area Director through the respective Area PRC Officer shall:

    1. Develop and establish policies and methods for the direction, control, review and evaluation of the Area and service unit PRC programs.

    2. Establish medical priorities for the care of eligible AI/AN people that will most effectively meet their needs within the funds available and are consistent with the National IHS medical priorities.

    3. Maintain records for planning and for controlling funds and furnish reports to the Director, DCC, at HQ as required.

    4. Allocate an equitable share of funds among the IHS/Tribal PRC programs based on established formulas agreed to by the Tribes.

    5. Coordinate appropriate contract activities with the Area Contracting Officer.

    6. Act promptly and appropriately on appeals of service unit PRC denials.

    7. Act promptly and appropriately on appeals from Pub. L. 93-638 operated PRC programs if the program has elected to follow the IHS appeals process.

    8. Monitor the CHEF cases.

    9. Establish general guidelines and policies for applying coordination of care practices and PRC quality assurance activities in the IHS Area facilities.

    10. Be responsible for internal controls related to the FMFIA.

~~3.~~ 2-3.~~3~~2 PURCHASED/REFERRED CARE DELIVERY AREA

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1. Purchased/Referred Care Delivery Area (PRCDA). ~~Currently the IHS provides services under regulations in effect on September 15, 1987 republished at 42 CFR Part 136, Subparts A-C, and which may be changed only in accordance with the Administrative Procedures Act (5 U.S.C. 553). 42 CFR Part 136, Subpart C defines a PRCDA as the geographic area within which PRC will be~~

made available to members of an identified Indian community who reside in the PRCDA. It should be clearly understood that residence within a PRCDA by a person who is within the scope of the Indian health program, as set forth in 42 CFR 136.12, creates no legal entitlement to PRC but only potential eligibility for services.

2. Services Needed But Not Available. Services needed but not available at an IHS or Tribal facility are provided under the PRC program depending on the availability of funds, the person's relative medical priority and the actual availability and accessibility of alternate resources in accordance with the regulations.

3. Established Purchased/Referred Care Delivery Areas. Established PRCDA are listed in the *Federal Register* (FR) Notices. The current PRCDA *Federal Register* Notice can be found on the IHS PRC Web site: https://www.ihs.gov/PRC/documents/PRCDA_FEDERAL_REGISTER_NOTICE_June_21_2007.doc

    1. A PRCDA typically consists of a county that includes all or part of a reservation, and any county or counties that have a common boundary with the reservation.

    2. Congress has statutorily created or re-designated a PRCDA through legislative enactments such as appropriations, restoration and/or recognition acts, public laws, etc.

    3. Some Tribes and particularly many of the newly recognized Tribes do not have reservations. When congress has not legislatively designated counties to serve as a PRCDA for such a Tribe, the Director, IHS, exercises reasonable administrative discretion to designate a PRCDA to effectuate the intent of Congress for the Tribe.

    4. The Director, IHS, publishes a notice in the FR when there are revisions or updates to the list of PRCDAs, including the designation of a PRCDA for a newly recognized Tribe.

4. 2-3.4 REDESIGNATION OF A PRCDA

1. Re-designation Request. The Tribal group(s) affected, or the IHS, (after working with the affected Tribal group(s)) may request for re-designation of a PRCDA. All requests for re-designation shall contain the following information:

    1. The estimated number of AI/AN people who will be included and/or excluded for eligibility of PRC. Note: The re-designation of a PRCDA may not result in the exclusion of AI/AN people eligible under 42 CFR 136.23(a)(1), i.e., reservation residents.

    2. The Tribal governing body's designation of the categories of AI/AN people to be included and/or excluded from eligibility for PRC; such as:

        1. members of the Tribe who live near the reservation; or

        2. AI/AN people who are not members of the Tribe but have close economic and social ties with the Tribe.

    3. The impact of the change in the PRCDA on the level of PRC being provided to eligible AI/AN people in the original PRCDA.

    4. The justification for the change in the PRCDA. The justification may include criteria used in establishing the PRCDA for the States outlined in 42 CFR 136.22, but are not limited to these criteria.

Commented [4]: This is redundant from the Definition's Section.

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Commented [6]: This is an undefined term. Please clarify who may make a request.

2. Submission of a Proposed PRCDA Change. Proposals for a change in a PRCDA must be submitted to the Director of the Area Office of the affected Tribe for review and forwarded to the Director, DCC, for appropriate action.

3. Requirements.

    1. The Area PRC Officer will analyze the request and will recommend acceptance or rejection of the request to the Area Director. For tribally-managed programs, analysis will be coordinated with the Area Tribal Project Officer for contracted programs or Self-Governance Coordinator for compacted programs. If another Tribe(s) is affected by the PRCDA designation/re-designation there must be consultation by the Area with the affected Tribe(s).

    2. The Area Director will then forward the recommendation, in writing to the Director, DCC, for appropriate action on the proposal.

    3. The Director, DCC, will review the request for the re-designation of the PRCDA, and apply the criteria outlined in Paragraph A above to the information submitted to support the request. If the submittal from the Area is complete, the Director, DCC will convene a meeting of an ad hoc PRCDA Designation /Re-designation Committee to consider the request.

        1. The committee members consist of IHS HQ representatives from the DCC; Office of Finance and Accounting/Division of Budget Formulation; Office of Public Health Support/Division of Program Statistics; Office of Management Services/Division of Regulatory Affairs; Office of Tribal Self-Governance; and Office of Direct Service and Contracting Tribes. The Director, DCC will chair the committee meeting.

        ~~3.~~2. [Information about the role and responsibilities of the Committee]

    4. The Director, DCC, shall prepare a report containing the findings of the PRCDA Designation /Re-designation Committee as to whether the criteria have been met. The Director, DCC, will submit the findings and recommendation to approve or deny the request via memorandum to the Director, IHS. If approval is recommended, the Director, DCC will draft the PRCDA re-designation *Federal Register* notice.

    5. The Director, IHS will inform the Tribe requesting the PRCDA designation/re-designation and the corresponding Area Director of the decision. The decision is final for the IHS ~~and cannot be appealed~~.

4. Tribal Consultation. The regulations at 42 CFR 136.22(b) state that after consultation with the Tribal governing body or bodies of those reservations included in the PRCDA, the Secretary may from time to time, re-designate areas within the U.S. for inclusion in or exclusion from a PRCDA. Consultation with the affected Tribe(s) occurs during the review of the request for re-designation, ~~but~~ and the IHS publishes a notice with requests for comments as part of the consultation process. (See Manual Exhibit 2-3-A for sample materials on re-designation of a PRCDA.)

    1. If IHS determines that a re-designation of a Tribe's PRCDA should be made, the IHS shall publish a notice with request for comments in the FR advising the public that the IHS proposes to re-designate a particular Tribe's PRCDA.

    2. The notice with request for comments shall include:

        1. a. The proposed action and the background information sufficient to provide the public an explanation for the Agency's decision.

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2. b. A statement as to the date when comments must be received. There must be at least a 30-day "comment" period from date of publication of the notice.

3. c. Reference to the legal authority and the name and address of the public official to whom comments should be addressed.

5. Effective Date of PRCDA Change. After a review of any comments received by the IHS after the publication of its notice with the request for comments, and after determining the Tribe's PRCDA should still be re-designated, the IHS shall publish a final notice advising the public that the IHS is re-designating a particular Tribe's PRCDA. The change in the PRCDA will be effective on the date of the final notice in the FR.

6. ~~F.~~Exception. Under certain circumstances, the notice and comment process described above, in paragraphs 2-3.4A-E, is not necessary in order to add counties to a Tribe's PRCDA. Instead, a memorandum from the Director, IHS, is mailed to the respective Area Director regarding the action resulting in a correction to, expansion of, or the creation of the Tribe's PRCDA with instructions to the Area Director to contact the Tribe with this information. Such circumstances include the following:

    1. the IHS inadvertently or mistakenly omitted the county from the Tribe's PRCDA list; or

    ~~2.~~ the Tribe's reservation was expanded or created by a proclamation issued by the Secretary of Interior or by congressional statute, e.g., Federal recognition of a Tribe.

~~5.~~ 2-3.5 PERSONS TO WHOM PRC WILL BE PROVIDED

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1. Authority. 42 CFR Part 136.23 is the appropriate citation for all correspondence to providers and AI/AN patients regarding eligibility for PRC. NOTE: This chapter should not be cited as the authority for making decisions on eligibility or payment denials.

2. Funds Available. There is no authority to authorize payment for services under the PRC program unless funds are in fact available.

3. Insufficient Funds. When funds are insufficient to provide the volume of purchased/referred care indicated as needed by the population residing in a PRCDA, priorities for service shall be determined on the basis of relative medical need, 42 CFR 136.23(e).

    1. Manual Exhibit 2-3-B demonstrates the process for determining the disposition for a patient being considered for PRC funding.

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    2. In the event that all PRC funds are depleted, referrals will be denied PRC payment or deferred. Medical referrals will still be made based on services needed by the patient. However, no payment or promise of payment can be made when there are no funds available.

    3. The Service Unit CEO will notify the Area Director when PRC funds are insufficient.

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4. Services.

    1. Any expenditure of PRC funds is limited to services that are medically indicated. See the Medical Priority list for services that may be included and those specifically excluded. The listing for PRC Medical Priorities can be found at the PRC Web site: https://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care

Commented [9]: This link, both when copied into a browser and when clicked, takes the reader to the main PRC webpage, where there is no obvious mention of a "Medical Priority list." We recommend providing a direct link or instructions for accessing the list.

    2. No PRC funds may be expended for services that are reasonably accessible and available at IHS facilities.

3. The determination of whether an IHS facility is "reasonably accessible and available" is made by the CEO based on the following criteria:

    1. Determination of the actual medical condition of the patient, i.e., emergent, urgent, or routine.

    2. The ability of the IHS to provide the necessary service.

    3. The level of funding available to provide PRC.

    4. Distance from the IHS facility.

    5. Inclement weather and/or unsafe travel conditions must be taken into consideration for time/distance to an IHS facility.

5. Guidelines. The following guidelines will be used in applying the above criteria:

    1. There must be a compelling reason to believe, upon review of the medical record and assessment of the patient's situation that without immediate medical treatment an individual's life or limb would have been endangered.

    2. Available PRC funds may be authorized for an emergency to the extent that the contract facility was the nearest available provider capable of providing the necessary services and the patient's condition dictated that he/she be transported to the nearest hospital.

    3. A list of diagnostic categories that have been administratively determined to be emergencies is included. This list is not all inclusive and other conditions may be included as an emergency when so determined by qualified IHS professionals. Medical and dental priorities may be found at the following: http://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care)

    4. Final decision as to classification of medical services as "emergency" will be based on review by an appropriate clinical health professional or by documented medical history.

    5. Services for an acute condition (urgent but not emergent) may be provided through PRC funds when the nature of the medical need of the patient, as determined by a professional, can best be met by using a private facility and sufficient PRC funds are available for this level of service.

    6. Routine health services (not emergent or urgent) should ordinarily be provided by IHS staff and facilities. Routine health services may be provided through PRC when the CEO has determined that sufficient PRC funds are available for this priority of medical service. As a general rule, routine health services will not be provided through PRC when an IHS facility capable of providing these services is within 90 minutes one-way surface transportation time from the person's place of residence. Weather conditions at the time of the illness should be considered when estimating time to the facility.

    7. If an IHS facility desires to change the criteria in 2-3.5E(6) for their patients, on the availability and accessibility of IHS facilities for routine health services, ~~they~~ it must request that the Area Office ~~to~~ issue a supplement on the criteria to be used for their facility. The new criteria should be developed with Tribal consultation and issued by the Area Office as stipulated in 1-1.2 IHM. This change will be posted and published to maximize knowledge among the AI/AN population served. This can be done through

Commented [10]: This link, both when copied into a browser and when clicked, takes the reader to the main PRC webpage, where there is no list of "medical and dental priorities." Previously, Manual Exhibits 2-3-D and E were listed as the resource containing the list. We recommend providing a direct link or instructions for accessing the list.

posters in clinic and hospital waiting areas, local media, brochures and wallet size information cards.

8. Purchased/Referred Care funds may be expended for services to support direct care individuals treated in an IHS facility to the extent that the individual is eligible for direct services. However, hospitals and clinics funds shall be used to support direct care whenever possible. Payment of costs for "contract to support direct care" specialty services (e.g., prenatal, podiatry, or orthopedic clinics) provided within the facility are permitted when patients are under the direct supervision of an IHS physician or a contract physician practicing under the auspices of the medical staff rules and regulations of the IHS facility. PRC funds are not to be used to support routine primary care that the facility is designed to provide. Manual Exhibit 2-3-C includes directives from IHS DCC, HQ on when PRC can be used in support of direct care. Expenditures must be consistent with the directives set forth therein.

~~6.~~ 2-3.6 ELIGIBILITY REQUIREMENTS

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1. Documentation. An AI/AN claiming eligibility for PRC has the responsibility to furnish the CEO with verifiable documentation to substantiate the claim. Each IHS facility should establish a policy on documentation. Manual Exhibit 2-3-D lists examples of acceptable documentation and examples to clarify the concept of residency.

2. Eligibility. Eligibility for PRC is governed by 42 CFR 136.23. The PRC program is not an entitlement program and thus, when funds are insufficient to provide the volume of PRC needed, services shall be determined on the basis of relative medical need in accordance with established medical priorities [42CFR 136.23(e)].

~~1.~~ To be eligible for PRC, an individual~~:~~ must be eligible for direct care as defined in 42 CFR 136.12; and either

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~~2.~~1. reside within the U.S. on a Federally-recognized Indian reservation; or

~~3.~~2. reside within a PRCDA and;

1. ~~are~~ be a member~~s~~ of the Tribe or Tribes located on that reservation; or

2. maintain close economic and social ties with that Tribe or Tribes.

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3. Close Economic And Social Ties. The basis for determining close economic and social ties is established by the Tribe(s) served and may include criteria such as:

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1. employment with a Tribe whose reservation is located within a PRCDA in which the applicant lives;

2. marriage to an eligible member of the Tribe; or

3. determination by the Tribe(s), including certification (a written decision by the legal governing body of a Tribe which has legal authority) from the Tribe(s) near where the individuals live that he/she have close economic and social ties with the Tribe whose reservation is located within the PRCDA in which the applicant resides.

4. Full-time Student. PRC will be made available to students who would be eligible at the place of their permanent residence, but who are temporarily absent from their residence, as follows:

1. Full time student programs such as high school, college (undergraduate and graduate) vocational, technical, or other academic education, during their attendance and normal school breaks. The service unit where the student was eligible for PRC prior to leaving for school is responsible for the student. These students remain eligible after the completion of the courses of study up to 180 days. After 180 days has elapsed the student is no longer eligible for PRC.

2. At all Bureau of Indian Affairs (BIA) Boarding Schools, PRC is provided for students during their full-time attendance, by the Area where the boarding school is located. Included are BIA off-reservation schools such as:

    1. Flandreau Indian School, Moody County, South Dakota;

    2. Circle of Nation School Wahpeton, Richland County, North Dakota;

    3. Sherman Indian High School, Riverside County, California;

    4. Riverside Indian School, Caddo County, Oklahoma; and

    5. Chemawa Indian School, Marion County, Oregon.

    Boarding school students can receive PRC whether or not they resided in a PRCDA before attending the school. While the student is on a scheduled break or vacation, the student's PRC permanent area of residence is responsible for payment of PRC services.

5. Transients. PRC eligible persons who are on travel or are temporarily employed, such as seasonal or migratory workers, remain eligible for PRC at their permanent residence during their temporary absence.

6. Persons in Custody. Usually, t~~T~~he cost of medical and related health services for eligible beneficiaries in custody of ~~(~~non-Indian~~)~~ law enforcement agencies is not the responsibility of the IHS, but is the responsibility of that particular agency. Where a tribe has contracted with non-Indian law enforcement for services, eligible beneficiaries in their custody is the responsibility of the IHS. All p~~P~~ersons in the custody of Indian law enforcement agencies, including the Bureau of Indian Affairs, will be considered eligible on the same basis as other beneficiaries of the Service. IHS does not provide the same health services in each area served and services provided will depend upon the facilities and services available (42 CFR 136.11(c)).

7. Persons outside the United States. Persons visiting a foreign country are eligible for PRC if the beneficiary is eligible for the PRC program and the purchase of care complies with the PRC regulations and the *Federal Acquisition Regulations* (FAR). See guidance in Manual Exhibit 2-3-E.

8. Other Persons outside the PRCDA. Persons, who leave the PRCDA in which they are eligible for PRC and are neither students nor transients, will be eligible for PRC for a period not to exceed 180 days from such departure.

9. Other Eligibility Considerations. An AI/AN is not required to be a citizen of the U.S. to be eligible for PRC. The AI/AN (e.g., a citizen of Canada or Mexico) must reside in the U.S. and be a member of a Federally recognized Tribe whose traditional land is divided by the Canadian border (e.g., St. Regis Mohawk, Blackfeet) or Mexican border (e.g., Tohono O~~"~~'O'odham, Kickapoo).

10. California Indians. Section 1679(a) of the Indian Health Care Improvement Act (IHCIA), states that the following California Indians shall be eligible for health services provided by the Service:

    1. Any member of a Federally-recognized Indian Tribe;

2. Any descendaent of an Indian who was residing in California on June 1, 1852, ~~but only~~ if such descendaent:

    1. is a member of the AI/AN community served by a local program of the Service, and

    2. is regarded as an Indian by the community in which such descendant lives.~~,~~

3. Any AI/AN who holds trust interests in public domain, national forest, or ~~AI/AN~~ reservation allotments in California.~~; and~~

4. Any AI/AN in California who is listed on the plans for distribution of assets of ~~California~~ ~~R~~rancherias and reservations under the Rancheria Act of August 18, 1958 (72 STAT. 619), and any descend~~e~~ant of such an Indian.

~~5.~~ Section 1679(b) of the IHCIA states that nothing in this Section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

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11. Indians Adopted By Non-AI/AN Parents. Indians adopted by non-AI/AN parents must meet all PRC requirements to be eligible for care (e.g., reside within a PRCDA).

12. Foster Children. American Indian/Alaska Native children who are placed in foster care outside a PRCDA by order of a court of competent jurisdiction and who were eligible for PRC at the time of the court order shall continue to be eligible for PRC while in foster care. Section 1680c(a) of the IHCIA, states in part:

    ~~1.~~ (a)(1) Any individual who— (1) has not attained 19 years of age;~~,~~ (2) is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible Indian;~~,~~ and (3) is not otherwise eligible for the health services provided by the Service, shall be eligible for all health services provided by the ~~s~~Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age."~~|~~.. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for services until 1 year after the date of a determination of competency."

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13. Non-AI/AN Pregnant Woman. A non-AI/AN woman pregnant with an eligible AI/AN's child who resides within a PRCDA is eligible for PRC during pregnancy through post-partum (usually 6 weeks). If unmarried, the non-AI/AN pregnant woman is eligible for PRC if the eligible AI/AN male states in writing that he is the father of the unborn child or such are determined by order of a court of competent jurisdiction. This will ensure health services to the unborn AI/AN child.

14. Non-AI/AN Spouses. Section 1680c(b) of the IHCIA, states in part: "Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Sservice, shall be eligible for such health services if all of such spouses or spouses who are married to members of each Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe or tribal organization providing such services~~of the eligible Indian~~."

15. Non-Indian. A non-AI/AN member of an eligible AI/AN's household who resides within a PRCDA is eligible for PRC if the medical officer in charge determines that services are necessary to prevent the spread of a communicable disease, control a public health hazard or an acute infectious disease, which constitutes a public health hazard.

The facility staff after determining that the patient is NOT eligible for PRC, shall obtain the signature(s) of the individual(s) acknowledging that they are not eligible for PRC, e.g., not residing within the PRCDA.

~~7.~~ 2-3.7 PURCHASED/REFERRED CARE MEDICAL PRIORITIES

Regulations [42 CFR 136.23(e)] permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of PRC indicated as needed by the population residing in a PRCDA. The IHS medical and dental priorities health priorities are found on the PRC Web site: https://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care Tribal programs when developing their own PRC Medical Priorities to meet Tribal needs may utilize IHS medical and dental priorities as guidelines.

The CMS *Medicare National Coverage Determinations Manual* and current medical literature will also be used as a basis for decision-making.

~~8.~~ 2-3.8 PAYER OF LAST RESORT REQUIREMENTS

1. Payor of Last Resort. Under 42 CFR 136.61 the IHS is the payor of last resort for services provided to patients defined as eligible for PRC, regardless of any State or local law or regulation to the contrary. Under 25 U.S.C. 1623(b), Congress ~~elevated~~ statutorily designated the IHS as a payer of last resort ~~status, superseding federal laws to the contrary~~ to the extent that other laws provide otherwise. Whether the alternate resource is regulated by contrary federal, state or local law, IHS intends to implement its statutory payor of last resort authority in accordance with existing regulations. Accordingly, the IHS will not be responsible for or authorize payment for PRC to the extent that:

    1. the AI/AN is eligible for alternate resources, defined in paragraph 2-3.89(G), or

    2. the AI/AN would be eligible for alternate resources if he or she were to apply for them, or

    3. the AI/AN would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for PRC or other health services, from the IHS or IHS programs. ~~Note; a "charity program" is not considered an alternate resource if the provider of services is absorbing the full cost of the care, but the charity program would be an alternate resource if the provider of services receives reimbursement for the costs of providing such care.~~

2. Eligibility for Alternate Resources.

    1. Refer to the Benefit Coordinator to determine whether the patient is eligible for alternate resources.

       GUIDELINE: Initially, the IHS should make a determination based upon reasonable inquiry whether the IHS patient applying for PRC is potentially eligible for alternate resources. Reasonable inquiry consists of ascertaining the patient's household size, income, and assets, and applying alternate resource program standards to the patient's information. Only IHS patients who, upon reasonable inquiry, are determined to be potentially eligible for alternate resources are required to apply for such resources. The IHS patients should not automatically be denied PRC benefits simply because of the possibility they might be eligible for an alternate resource.

    2. Advise the patient of the need to apply for alternate resources and refer to the Benefit Coordinator.

Commented [11]: Without a section number, this provision appears to relate only to provision 15. We suggest moving it up in the Section so that it immediately follows the documentation provision at Section 2-3.6.1.

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Commented [12]: This link, both when copied into a browser and when clicked, takes the reader to the main PRC webpage, where there is no list of "medical and dental priorities." We recommend providing a direct link or instructions for accessing the list.

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There is no section G in the draft PRC chapter update. This reference needs to be corrected to specify that this is referring to 42 CFR 136 Subpart G.

GUIDELINE: The IHS will provide the patient with a written notice that explains why it is necessary for him or her to make a "good faith" application to the alternate resource program. The notice should include information such as the need to schedule and attend scheduled appointments, the necessary documentation to bring to the appointments, and availability of transportation to appointments.

3. Benefit Coordinator will assist the patient in applying, especially where it is evident that the patient is unable to apply or is having difficulty with the application process.

   GUIDELINE: The IHS shall include in its written notice that if a patient is unable to apply or is having difficulty applying for alternate resources, the facility staff (Benefit Coordinator) will assist with the application process.

   Each facility will document attempts to assist patients in applying for or completing an alternate resource application. Documentation of assistance for application to the alternate resource program is necessary to support a decision whether to authorize payment of PRC funds.

3. Completed Application to Alternate Resource Program. If a completed application to the alternate resource program results in a denial, the alternate resource program denied payment for a valid reason (e.g., the patient is over income eligibility standards or not a resident of the county), and the AI/AN patient's medical bills and the AI/AN is otherwise PRC eligible, the IHS should pay the AI/AN patient's medical bill.

   An AI/AN patient cannot be denied alternate resources that he or she would be eligible for under State or local law or regulation simply because of his or her eligibility through the IHS and PRC Program.

4. Failure to Follow Alternate Resource Procedures. There are two instances when IHS will not pay the provider for medical bills incurred by an otherwise PRC eligible patient:

   1. When the patient willfully or intentionally fails to apply or fails to complete an alternate resource application,. ~~The~~the IHS facility staff will provide written notice to the patient~~s~~ that a PRC denial letter will be issued, unless the patient—within 30 days after receiving the notice—either (1) ~~if~~ completes an alternate resource application ~~is not completed~~, or (2) ~~if the patient does not~~ contact~~s~~ the facility staff for assistance in completing the application ~~within 10 days after the receipt of the notice, a PRC denial letter will be issued~~.

      ~~1.~~ If an alternate resource ~~program~~ issues a denial because the applicant failed to apply or failed to complete the application and the PRC file is well documented with attempts to assist the applicant, the PRC office should issue a PRC denial to the patient and a copy should be forwarded to the provider.

   2. When the provider is not able to receive payment from an alternate resource ~~program~~ because of the provider's failure to follow proper procedures (e.g., non-timely filing of the patient's alternate resource, 42 CFR 136.30(h)(3)), neither the patient nor IHS will be responsible for the medical bill, even if the AI/AN patient is otherwise PRC eligible ~~(42 CFR 136.30(h)(3)~~.

5. Notice to Providers. The Director, PRC, will inform private providers (i.e., non-IHS facilities and practitioners providing medical services to IHS beneficiaries) of the PRC eligibility criteria and requirements. Such information can be provided through terms in a contract with the provider, by separate notice upon referral of a patient to the provider, or by general notification to a provider when there are continuous referrals of patients to that same provider. The Director, PRC will inform providers that:

Commented [13]: The reference to Manual Exhibit 2-3-A, Written Notice, Patient Requirement for Application to Alternate Resources, was removed. We recommend that the IHS retain this reference because it is useful.

Commented [14]: Similarly, the reference to Manual Exhibit 2-3-B, Authorization for Use or Disclosure of Health Information (Form 810), was removed. We recommend that the IHS retain this reference because it is useful.

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The language should reflect that in this circumstance, the PRC office "will" issue a PRC denial and copy "will" be forwarded to the provider, rather than language that the PRC office "should" issue a PRC denial and copy to the provider.

1. an IHS medical referral does not constitute a representation of eligibility under the PRC program (see Manual Exhibit 2-3-F);

2. the IHS expects the provider to apply for alternate resources as it would for its non-AI/AN patients;

3. the provider must investigate with each patient, his or her eligibility for alternate resources and should assist the patient in completing necessary application forms;

4. if an alternate resource is available, its use is required and the IHS or the FI shall be promptly notified of any payment received; and

5. the IHS or FI will reject claims where the provider fails to investigate other party liability.

6. Payor of Last Resort Rule. The use of alternate resources is mandated by the Payor of Last Resort Rule, 42 CFR 136.61.

    1. An individual is required to apply for an alternate resource if there is reasonable indication that the individual may be eligible for the alternate resource.

    2. Refusal to apply for alternate resources when there is a reasonable possibility that one exists, or refusal to use an alternate resource, requires the denial of eligibility for PRC.

    3. An individual is not required to expend personal resources for health services to meet alternate resource eligibility or to sell valuables or property to become eligible for alternate resources.

7. Alternate Resources. ~~All IHS or Tribal facilities that are available and accessible to an individual are considered alternate resources.~~ Alternate resources, as defined by 42 CFR 136.61(c), means "health care resources other than those of the Indian Health Service. Such resources include health care providers and 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, Medicaid), State or local health care programs, and private insurance." ~~Other alternate resources to pay for private sector services would include, but not be limited to, Medicare, Medicaid, Vocational Rehabilitation, Children's Rehabilitative Services, Local or Private Insurance, State Programs and Crime Victims Act. Also see 42 CFR 136.61(c).~~ The reference to "local" does not mean "tribal," and "private health insurance" does not mean tribal self-insurance.

    1. Such resources also include, but are not limited to: the Children's Health Insurance Program under the Social Security Act; the Veterans Health Administration; other Federal health care programs; Vocational Rehabilitation; Children's Rehabilitative Services; Crime Victim Compensation Program under the Victims of Crime Act, 34 U.S.C. § 20101-20111; and student health insurance purchased by students with grants provided for that purpose.

    ~~4.~~2. A charity or indigent care program for which an individual is eligible, or would be eligible but for being eligible for PRC, shall be considered an alternate resource.~~A charity or indigent care program offered by a provider of services is not considered an alternate resource if the provider of services is absorbing the full cost of the care, but the charity or indigent care program will be considered an alternate resource if it receives reimbursement for the costs of providing such care from state resources or other institutions~~.

    3. Coordinating Benefits with Health Care Coverage Purchased under 25 U.S.C. 1642 ('sponsorship"). IHS considers sponsorship ~~through indemnity~~of insurance plans to be an alternate resource under the payer of last resort rule.

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8. Tribal Self-Insurance Plans. Tribal self-insurance plans are not alternate resources, for any purpose except as provided for in 25 U.S.C. § 1621e(f). Reinsurance or stop loss insurance on tribal self-insurance may be considered an alternate resource when the reinsurance ~~assume~~or stop loss insurance is paying the costs~~ payment for costs~~. However, tribal self-insurance that has reinsurance or stop loss insurance does not become an alternate resource because of the reinsurance or stop loss insurance.

~~7.~~9. Qualified Health Plan from a Federal or State Marketplace.

1. Qualified Health Plans (QHP) are available through the Marketplace where consumers can compare health insurance options. Pub. L. 111-148, Patient Protection and Affordable Care Act (March 23, 2010) provides special protection for members of federally recognized tribes from cost-sharing (deductibles, coinsurance and copayments) for the provision of essential health benefits in a QHP.

2. Zero Cost-Sharing plans are only available to members of federally recognized Tribes and Alaska Natives with incomes at or between 100% and 300% of the federal poverty level.

    1. In-Network Providers — a referral is not needed for the patient to receive an EHB from an "in-network" non-Indian health care provider.

    2. Out-of-Network Providers — an authorized PRC referral is required to cover out of network charges. Out of network charges are not a co-pay, co-insurance or deductible.

3. Limited Cost-Sharing plans are available to members of federally recognized Tribes and Alaska Natives with any level of income. There is no cost sharing as long as the service is referred through a PRC program.

    1. In-Network Providers - A PRC referral is required to avoid cost sharing for essential health benefits (EHB). The PRC referral must state it is for all EHB for the episode of care.

    2. In-Network Providers — A QHP referral from the QHP primary care provider may be required (depending on the terms of the QHP). PRC staff need to confirm with the QHP and assist the beneficiary in acquiring this referral.

    3. ~~c.~~Out-of-Network Providers — An authorized PRC referral is required to cover any out-of-network charges and to cover authorized charges up to the PRC rate.

4. Standard and Silver Cost-Sharing plans are QHPs that are available to IHS beneficiaries that are not members of a federally recognized tribe or Alaska native but are otherwise eligible for IHS.

    1. All Providers — An authorized PRC referral is required to pay any cost sharing expenses after the QHP payment.

    2. All Providers - A QHP referral from the QHP primary care provider may be required (depending on the terms of the QHP). PRC staff need to confirm with the QHP and assist the beneficiary in acquiring this referral.

5. AI/ANs with Medicaid who have ever received a service (e.g., a primary care, dental, behavioral health visit etc.) from the Indian Health Service, tribal health programs, or through a PRC referral are exempt from cost-sharing which includes copayments or

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coinsurance for Medicaid services. Therefore, there is no cost to the PRC program for Medicaid services provided. AI/ANs can self-attest that they have ever received services from IHS or a tribal health program.

6. Students whose grant includes funds ~~for health services shall be required to use the grant funds~~ to purchase available student health insurance shall be required to do so~~. Individuals who receive funding to purchase insurance shall be required to use such funds for health care purposes~~ and such insurance shall be considered an alternate resource.

7. When an alternate resource is identified that will require the IHS to pay a portion of the medical care costs, the appropriate IHS form, IHS form 843 will be processed immediately to obligate the funds for the estimated balance, after alternate resource payment, with corresponding distribution of the form. In these situations, the IHS form, IHS form 843, must clearly indicate that payment will not be processed unless and until the provider has billed and received payment from the alternate resource. It is proper and necessary to require either an explanation of benefits (EOB) or, in cases of denial from the alternate resource, a copy of the denial notice for the record.

~~8. Exception to the IHS Payor of Last Resort: Tribal Self-Insurance Plans. For purposes of IHS administered PRC programs, the Agency will not consider tribally-funded self-insured health plans to be alternate resources for purposes of the IHS Payor of Last Resort Rule.~~

~~9. Coordinating Benefits with Health Care Coverage Purchased under 25 U.S.C. 1642 ("sponsorship"). IHS considers sponsorship through indemnity to be an alternate resource under the payer of last resort rule~~.

~~9.~~ 2-3.9 AUTHORIZATION FOR PURCHASED/REFERRED CARE

1. Notification. The following notification requirements apply to all categories of eligible AI/AN patients including students, transients, and patients who leave the PRCDA. A notification is not a guarantee that authorization will be provided for payment, but notification must be provided for authorization to be considered. Notification requirements as described in 42 CFR 136.24 will be followed, including:

    1. No payment will be made for medical care and services obtained from non-Service providers or in non-Service facilities unless the requirements listed below have been met and a purchase order for the care and services has been issued by the appropriate authorizing official to the medical/dental/behavioral health care provider.

    2. In non-emergency cases, an eligible AI/AN, an individual or agency acting on behalf of the patient, or the medical care provider shall, prior to the provision of medical care and services, notify the appropriate official of the need for services and supply information that the authorizing official deems necessary to determine the relative medical need for the services and the individual's eligibility. The requirement for notice prior to providing medical care and services under this paragraph may be waived by the appropriate official, if the official determines that providing notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.

    3. In emergency cases, the patient, an individual or agency acting on behalf of the patient, or the medical care provider shall, within 72 hours after the beginning of treatment for the condition or after admission to a health care facility, notify the appropriate official of the admission or treatment and provide information to determine the relative medical need for the services. The 72-hour period may be extended if the appropriate official determines

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that notification within the prescribed period was impracticable or that other good cause exists for the failure to comply.

4. Section 1646 of the IHCIA, allows the elderly and disabled 30 days to notify the IHS or Tribal program's CEO of emergency medical care received from non-IHS medical providers or at non-IHS medical facilities.

5. The following definitions for an elderly and disabled individual are to be used until further defined and published in the FR.

    1. The IHS defines elderly as an individual who is 65 years of age or older.

    2. A disabled individual who has a physical or mental condition that prevents him or her from reasonably providing or cooperating in obtaining the information necessary to notify the IHS of his/her receipt of emergency care or services from a non-service provider or facility within 72 hours after the non-service provider began to deliver the care.

2. Notification for Students, Transients and Patients. Authorization for PRC to students, transients, and patients who leave the PRCDA will be the responsibility of the IHS Area from which the patient left.

    If a PRC eligible patient presents to an IHS facility other than the facility of residence for direct care and needs PRC, the facility Director, PRC, will contact the patient's facility of residence for instructions in patient management with respect to PRC authorization or denial. The patient will be informed of his or her responsibility to modify his or her facility of residence. Payment for PRC is the responsibility of the patient's area of residence in accordance with PRC regulations at 42 CFR 136.24, when notification is provided prior to the authorization and/or provision of PRC services that are referred out by a facility not in the patients area of residence. These guidelines do not preclude formal arrangement for fund transfers within or among Areas to provide PRC for patients from other IHS Areas.

3. Payment. Payment shall be made in accordance with the provisions of the contract or purchase order and other provisions including IHS payment rules set forth in 42 CFR 136 Subpart D and Subpart I (collectively referred to as PRC rates). Every effort must be made to assure the AI/AN patient being referred from an IHS facility is notified at referral time of his or her eligibility status for PRC. In cases where determination of eligibility cannot be made before referral, the individual will be notified in writing prior to obtaining care that the IHS or Tribe may not be responsible for bills incurred.

    1. PRC Rates for services furnished by Medicare-Participating Hospitals - 42 CFR 136 Subpart D Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), requires hospitals and critical access hospitals to participate in PRC programs. Section 506 directed the Secretary to set forth a payment methodology, payment rates, and admission practices through regulation for the PRC services provided by Medicare-participating hospitals. Any payments made under the PRC program are considered payment in full and the patients must not be billed for any remaining balance. See ~~42 CFR 482.29~~, 42 CFR 136.30 and also 25 U.S.C. 1621u.

        1. In the event a hospital is balance billing patients after PRC payment.

            1. Notify the hospital of the law, if the hospital refuses to comply.

Commented [20]: It is unclear why "students" and "patients" was removed from the heading but left in the text. References should be consistent.

Commented [21]: There is no such citation in the regulations.

The correct citation is 42 CFR 489.29 (not 42 CFR 482.29).

2. Notify the Area PRC Officer who will notify the Regional CMS Native American Contact (NAC).

3. The NAC, pursuant to [cite source], will notify the CMS Survey and Certification Division.

4. The Survey and Certification Division, pursuant to [cite source], will contact the hospital and allow them to have a 90 day corrective action plan to remedy the infraction.

5. After 90 days if the action has not been remedied, CMS will pull the hospital's CMS certification, pursuant to [cite source].

~~6.~~ 2. (2) PRC Rates for physicians and non-hospital supplies and services 42 CFR 136 Subpart I.

~~2.~~ a. IHS will not do business with a provider or supplier who will not accept the PRC Rate or negotiate a fair and reasonable rate based upon the providers most favored customer rate, meaning the lowest rate the provider will accept from other payers, including any discounts.

2. ~~b.~~ The provider accepts the PRC rate and cannot balance bill the patient if any of the following have been done:

    1. The services were provided based on a Referral, as defined in 42 CFR 136.202; or

    2. The health care provider or supplier submits a Notification of a Claim for payment to the I/T/U; or

    3. The health care provider or supplier accepts payment for the provision of services from the I/T/U.

3. ~~c.~~ It is mandatory to enter a provider's information into the Provider Tracking Tool located at:

    https://home.ihs.gov/OtherPrgms/IHPES/ORAP/TPICPSA/index.cfm?module=prc&option=admin&fn=doPRCvalidate

4. Patients under Treatment at the Expiration of 180-Day Eligibility Period. Individuals under treatment for a condition that may be deferred to a later date (e.g., a person with a meniscal tear of the knee that will require surgery to repair at some point) will cease to be eligible at the expiration of the 180-day period after leaving their PRCDA. Individuals under treatment for an acute condition shall remain eligible as long as the acute medical condition exists. For example, if a PRC eligible person is stricken with acute appendicitis 179 days after leaving the PRCDA, necessitating hospitalization and surgery extending beyond the 180-day eligibility period, the patient would remain eligible until he/she is deemed cured. This does not include continued treatment of chronic conditions, for example, obstetrical deliveries that occur after the 180 period.

5. Responsibility to Notify AI/AN Community of PRC Requirements. American Indian/Alaska Native people served by the PRC program will be informed of policies regarding the administrative requirements for approval of PRC payments for services, and the title(s) of the person(s) who must be notified when PRC is required. Examples of notification include publication in local community and/or Tribal newspapers and posting of notices on bulletin boards in public waiting areas in IHS facilities. Changes in local policies or administrative requirements will be published

Subsection 2-3.9(3)(1)(1)((3) should read: "The NAC, pursuant to 42 CFR 489.29, will notify the CMS Regional Director."

2-3.9(3)(1)(1)((4) should read: "The CMS Regional Director pursuant to 42 CFR 489.29 will contact the hospital and allow them to have a 90 day corrective action plan to remedy the infraction."
The imposition of the 90 day CAP by CMS is unclear, as it does not appear in the applicable regulations or the guidance letter. Whether CMS has given additional information to IHS on this topic is unknown.

The correct citation is 42 CFR 489.53.

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This section seems to be based on Subpart I which applies only to outpatient services (Subpart I, 136.201-136.204). Inpatient MLR is in Subpart D. 136.30-136.32.

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and posted including notification to providers who may or may not have contracts with the IHS service unit.

6. Purchase/Referred Care Authorization Numbering System. A uniform numbering system has been developed to use when the IHS facility is issuing the IHS-843 purchase order documents. The use of this system will preclude two or more facilities from using the same document number and will assist in identifying the Area and facility.

    1. The number has four components and consists of ten digits.

    2. The four components are: 00 0 00 00000.

    3. The first two digits of this sequence are the last two digits of the fiscal year being charged for the services. If the number less than ten, a 0 is used as the first digit. Example: the fiscal 2009 is 09 and the fiscal year 2013 is 13.

    4. The second component is an alpha code to identify the Area. The alpha codes are:

        - Great Plains C Navajo N
        - Alaska A Oklahoma O
        - Albuquerque Q Phoenix X
        - Bemidji D Portland P
        - Billings B Tucson S
        - California L Nashville U

    5. The third component consists of the two digit site specific code that identifies the facility being charged for the services. The digits are the standard location code as used in the fiscal accounting system.

    6. The fourth component has five digits and is the sequential number for the documents to be charged to each facility. These numbers will begin each fiscal year with 00001 and continue sequentially for the year. Facility supplemental authorizations, if necessary, will be numbered with the original numbers plus a facility suffix of S-1, S-2, etc.

7. The PRC Authorization Flow Chart. The flow of a PRC purchase order from initial request through processing and closeout is diagramed in Manual Exhibit 2-3-G. Many aspects of PRC and other activities are incorporated in this general flow.

Commented [23]: We cannot properly comment on this provision because the IHS has not released or made publically available a revised version of Manual 2-3-G.

2-3.10 ELECTRONIC SIGNATURES

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1. Electronic Signature for PRC Purchase Order. Pub. L. 106-229 (Electronic Signature in Global National Commerce Act) provides for the use of electronic signatures. The electronic signature promotes the use of electronic contract formation, signatures, and record keeping in private commerce by establishing legal equivalence between:

    1. Contracts written on paper and contracts in electronic form;

    2. Pen and ink signatures and electronics, and;

3. Other legally required written documents (termed "records") and the same information in electronic form.

4. This establishes guidance and direction for electronic signature of IHS-843 in accordance with Pub. L. 106-229. Ensuring compliance with the Privacy Act, Health Insurance Portability and Accountability Act (HIPAA), and confidentiality requirements are the responsibility of each Area PRCO.

2. Accessing Electronic Signature. Individuals will only be provided the ability to access the E-SIGN system if they have completed all security requirements and possess current procurement authority (see Manual Exhibit 2-3-H).

2-3.11 PAYMENT DENIALS AND APPEALS

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When a patient is denied PRC or if a medical provider may reasonably think that the Director of the IHS/Tribal program is a party to payment for services provided to an eligible patient, both the patient and the provider must be notified in writing of the denial with a statement containing all the reasons for the denial. Refer to the *PRC/Management Information System Manual* (version 3.2) denial package. An example of a denial letter can be found in Manual Exhibit 2-3-I.

1. Denial Notice. The denial notice must inform the applicant that within 30 days from the receipt of the notice the applicant:

    1. May request a reconsideration of the denial (appeal) by the appropriate service unit CEO and the request for reconsideration must contain additional information not previously provided.

    2. May appeal the original denial by the CEO to the appropriate Area Director, if there is no additional information on which to base reconsideration in accordance with Section (I), above. Requests for reconsideration and appeals may be submitted by providers. The provider will be considered as acting on behalf of the patient. A response must be made to the provider and a courtesy copy of such response is provided to the patient.

    3. May appeal to the Area Director if the CEO upholds the service unit's original denial. When the Area Director upholds a denial, the applicant must be notified in writing of the denial and that an appeal may be submitted in writing to the Director, IHS, within 30 days.

    4. May appeal to the Director, IHS, if the Area Director upholds the denial. The decision of the Director, IHS, is the final adjudication of the appeal of the denial. A written notice of the decision will be sent to the claimant stating they have no further appeal rights.

2. Failure to Follow Appeal Process. If the claimant fails to follow procedures, the request for reconsideration of an appeal may be denied. A written notice of denial will be sent to the claimant stating they have no further appeal rights.

3. Three Levels of Appeal. The IHS appeals process applies to IHS administered PRC programs and those PRC programs administered under Title I and V programs that have negotiated and incorporated into their funding agreements that the IHS appeals procedures will be utilized. The PRC regulations currently in effect at 42 CFR 136.25 allows only three levels of appeal:

    1. request for reconsideration of the appeal by the CEO,

    2. appeal to the Area Director, and

3. final administrative appeal to the Director, IHS.

4. Tribal Appeals Process - Contractors. The IHS will conduct the appeal process for a Tribally-managed PRC program, if the Tribe has retained IHS functional shares with their respective Area Office. Therefore, before an Area Director or the Director, IHS, may agree to adjudicate a claim, the Tribe must have left sufficient resources with the IHS to conduct the appeal process. It is not sufficient to have it negotiated and incorporated into a Tribe's funding agreement that the IHS appeals procedures will be utilized without evidence that (1) sufficient funds have been withheld to pay for the costs to operate the appeals process for the ~~a~~ Tribe or tribal organization; or (2) the PRC appeals process is included in the Tribe or tribal organization's buyback agreement with the IHS.

~~5.~~ Tribal contractors are not required to utilize the IHS appeals process described in the IHM, however, pursuant to 25 U.S.C. 5324(g) and 25 U.S.C. 5397~~-~~(e), a Tribe must provide a written appeals process that is functionally equivalent to the process in 42 CFR 136.25.

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~~6.~~5. Tribal Appeals Process - Title I and V Programs. Title I and V programs that have negotiated and incorporated into their funding agreement a provision that the IHS appeals procedures will be utilized; shall agree to the following terms and conditions:

1. The Area Director and the Director, IHS, will utilize ~~the IHS regulations and interpretations, not~~ Tribal criteria and interpretations~~,~~ to adjudicate claims. The IHS utilizes its medical priorities and policies to adjudicate IHS PRC claims.

2. The Title I or V programs shall provide necessary documentation required for claims adjudication. Depending on the nature of the claim, documentation such as medical records, date of notification, residency documentation, etc., could be required.

3. The IHS conducts the appeals process from Title I and V programs without assuming any fiscal responsibility. When an Area Director, or the Director, IHS, issues a determination overturning the Tribal denial of payment authorization, it is the responsibility of the Tribe not the IHS to pay the bill.

~~7.~~6. Title I and Title V Program Denials of PRC Payment. IHS will not review appeals for those Tribes that have assumed the PRC appeals function.

~~8.~~7. Tribes are NOT Required to Implement Regulations the Same as the IHS. Title I and Title V programs must, in accordance with 25 U.S.C. 5324(g) and 25 U.S.C. 5397(e), make eligibility determinations in accordance with the IHS eligibility regulations in the CFR, Title 42, Part 136. However, there are provisions of the IHS eligibility regulations that allow different standards to be set. For example, Tribes and Tribal organizations may adopt a different standard for "close economic and social ties" for PRC eligibility (see 42 CFR 136.23), Tribes could also adopt different medical priorities. If the appeals process has been assumed by the Tribal contractor under Pub. L. 93-638, as amended, individuals who are dissatisfied with Tribal determinations of eligibility must pursue Tribal administrative remedies. Issues that should be considered by Tribes in the development of appeals policies and procedures include:

1. Development of a formal appeals procedure and levels of appeal.

2. Establishment of clear program policies concerning eligibility, medical priorities, referrals, and notification of all parties.

3. Protection of individual rights to due process.

~~9.~~8. Responsibilities.

1. Chief Executive Officer. The CEO or authorized designee is administratively responsible for creating and maintaining a file on each denial of PRC.

2. Area Director. The Area Director or authorized designee is responsible for:

    1. establishing individual alphabetical patient appeals files that contain all documentation in chronological order for all appeals, and

    2. for forwarding copies of appeal case files to the Director, DCC, HQ upon request.

~~10.~~9. Information Copies. The Area Director or his or her authorized designee, will not routinely forward information copies of all denials to the Director, DCC. The files will be sent only when the Director, DCC, or his or her designee requests a specific file.

~~11.~~10. Controlled Correspondence. The Director, DCC, will send by secure fax or encrypted email (such as the IHS secure data transfer service) incoming controlled correspondence to the appropriate Area(s) PRCO with a request for information. Each PRCO will analyze the correspondence and submit all necessary documentation to the Director, DCC, in order that he or she will be able to prepare a response. If there were no appeals to the Area Office PRCO or CEO, the Director, DCC, will be notified immediately. Copies of all determinations issued within the Area will be submitted to the Director, DCC. If an appeal(s) was submitted to either the CEO or Area Director and the CEO or Area Director has not issued a determination, a briefing memorandum is to be submitted to support the actions that have been taken.

~~12.~~11. Appeals Process - Division of Contract Care. The Director, DCC, is responsible for processing all PRC appeals sent to the Director, IHS. The Director, DCC, or his or her designee, will:

1. Ensure that all required correspondence is included in chronological order.

2. Routinely request information from the Area PRCO and other sources as needed.

3. Analyze the issues contained in the appeal and processes the appeal to the extent issues can be handled within established policy.

4. Refer all appeals that involve questions of medical judgment to the medical review to the Director, Office of Clinical and Preventive Services.

5. Refer an appeal that involves legal questions or requires legal analysis review to the OGC for legal advice.

~~13.~~12. Final Decision. The decision of the Director, IHS, shall constitute the final administrative action in the appeal process.

~~14.~~13. Appeal File. The appeal file shall contain: all denial letters, all briefing documents or memorandums prepared in connection with any recommendation to the CEO or Area Director regarding such denial; all correspondence to IHS from claimant or claimants representative; any other relevant correspondence, maps, bills, or receipts; records of telephone calls to or from claimant or claimant's representative; correspondence relative to any inquiry (i.e., Congressional, State official, etc.) made on behalf of the claimant; and pertinent correspondence relative to prior appeal by the same claimant.

~~15.~~14. Retention Period. Each appeal record/file will be maintained for a period of 6 years and 3 months after the IHS PRC appeals process has been exhausted.

2-3.12 MANAGEMENT OF PURCHASED/REFERRED CARE FUNDS

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1. Allocation of PRC Funds. The allocation of PRC funds to the Areas are determined by three primary methods: historical base funding, annual adjustments, and program increases. The PRC funds are then distributed from the Areas to the individual PRC programs. As a portion of the overall PRC funding methodology, the PRC Allocation Formula, is designed to accommodate for any new program increases and is in compliance with the IHS Budget Execution Policy. However in consultation with Tribes, Areas have the authority to redistribute new program increases using a different methodology other than the PRC Allocation Formula.

2. Each Area, using an allocation formula other than the PRC Allocation Formula to distribute new program funding, shall notify the Director, DCC in writing. The notification must include a copy of the formula used, any relevant information that explains the method used, a description of the consultation held with affected Tribes, and the distribution amounts to PRC programs in the Area. Notification must be provided before implementing any allocation formula other than the PRC Allocation Formula.

3. Use of PRC Funds for Staff Administering the PRC Program. PRC funds may be used for staff administrating the PRC program when the following conditions are met:

    1. The PRC program is purchasing care beyond Medical Priority II

    2. Each Area Service Unit PRC program reports annually the medical priority level the program is purchasing, the number, grade level and salary of full or part time employees supported by PRC funds and the number of denied and deferred services for Priority II care to the Area Director.

    ~~3.~~ The Area Director shall report~~s~~ by October 10, annually to the Director, DCC, ORAP, for each Area Service Unit, the medical priority level each program is purchasing, the number, grade level and salary of full or part time employees supported by PRC funds and the number of denied and deferred services for Priority II care.

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4. Commitment Register. Management of PRC funds in accordance with the FMFIA requires that the PRC Commitment Register(s) will be maintained at each authorizing location. The PRC Commitment Register(s) is maintained electronically in CHS/MIS. The PRC Commitment Register contains the following minimum information:

    1. Date of Authorization

    2. Authorization Number

    3. Provider Name

    4. Patient Name

    5. Date of Service

    6. Allowance Amount

    7. Estimated Cost of Service

    8. Balance of Funds

5. Funds Status Report. The PRC funds status report is to be submitted to the Area PRCO at least once a month. A summary of the PRC fund balance shall be provided to the CEO, the Clinical

Director, and PRC review committee at least once a month. NOTE: The summary may also be provided to the Tribal Health Director; however, using this process is purely optional for Tribal PRC programs. A sample of a Status of Funds report can be seen in Manual Exhibit 2-3-J.

6. Purchased/Referred Care Spending Plan. Programs are to maintain at least a weekly spending plan by prorating their allocations by the appropriate amount of weeks for each allocation. Weekly spending plans are to be monitored by the local PRC manager, shared with the PRC review committee and Service Unit administration. Spending plans must be available for review by the PRCO. For small PRC programs the frequency of the spending plan can be determined on a case by case basis. The PRC program must request a change for the spending plan frequency in writing to the Area Director through the Area PRCO. A sample spending plan can be found in Manual Exhibit 2-3-K.

7. Services Authorized That Working Day. An entry will be made on the commitment (document control) register for each obligation of funds, or modification of or adjustment to obligation of funds. The entries will be made daily to reflect the services authorized that working day. Entries should not be delayed beyond 5 working days from the date of an authorized referral or notification of an authorized claim by the PRC review committee.

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2-3.13 FOLLOW-UP OF OUTSTANDING AUTHORIZATIONS

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Each IHS PRC program will establish a follow-up system for all authorizations that have not been completed and returned within 90 days of issuance. Manual Exhibit 2-3-L has a recommended form letter for use in these follow-ups.

2-3.14 RECONCILIATION OF CHS/MIS to UFMS REGISTER

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The PRC Commitment Register (CHS/MIS) will be reconciled with the official financial management report, each month of the fiscal year. The recommended procedures for reconciliation of the Commitment Register are provided in Manual Exhibit 2-3-M.

2-3.15 DATA REPORTING

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The appropriate workload and fiscal codes will be entered into the data system, as specified in the FR dated January 20, 1994, Volume 59, Number 13, "Core Data Set Requirements; Notice."

2-3.16 CATASTROPHIC HEALTH EMERGENCY FUND (CHEF)

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1. Background. The CHEF is the congressionally appropriated fund for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the IHS.
   Until such time as regulations are published, the annually issued HQ CHEF guidelines will continue to serve as interim policy governing the CHEF program for all PRC programs.

2. Access to the CHEF Fund is on a Cost Reimbursement Basis. All IHS PRC programs must first obligate and expend funds and meet the appropriate threshold to be reimbursed from the CHEF.

3. Cost Threshold. The CHEF threshold is adjusted by the Director, DCC, within the range established by law. The IHS Director, DCC, will provide instructions annually. Whether a case meets the threshold amount is determined by only including those costs remaining after payment has been made by Federal, State, local, private health insurance, or other applicable alternate resources.

4. Alternate Resources. The requirements for alternate resources must be met to access the CHEF.

5. Reimbursement. All PRC programs must submit CHEF cases through their Area PRC programs for coordination. Any CHEF reimbursement shall be applied only to cases that have been reviewed and approved by the CHEF Manager; any amounts not used because of payments by alternate resources or cancellations must be returned to the HQ CHEF account. For specific details on the CHEF, reference the current, annually issued CHEF guidelines located on the IHS PRC Web site: http://www.ihs.gov/PRC/Instructions on catastrophic case processing and a check list for submitting/processing a CHEF case can be found in Manual Exhibit 2-3-N.

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If the link is intended to be http://www.ihs.gov/prc, then we note that it is not obvious where to find these instructions. We recommend providing a direct link or instructions for accessing the annually issued CHEF guidelines.

2-3.17 FISCAL INTERMEDIARY

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1. Purpose. The purpose of the fiscal intermediary (FI) is to operate a nationwide centralized medical, dental and behavioral health claims processing and payment system to:

    1. collect, compile, and organize workload and financial data; and

    2. provide statistical and financial reports to the IHS for the administration of its PRC program.

2. Authority. 42 U.S.C. 238m

3. Fiscal Intermediary Operations. For a description of the FI internal operations information and most current payment codes refer to the most current version of the *FI Reference Manual* for IHS/PRC. The *FI Reference Manual* is updated to reflect changes or incorporate information on an as-needed basis. Obtaining access to this manual is provided in the following section.

4. Accessing the FI Data System. The IHS is mandated to protect patient's medical information from all security risks. Changes to the FI data system allowing access to data and the ability to communicate through local area networks shall include provisions to ensure patient confidentiality. Ensuring compliance with the Privacy Act, HIPAA privacy regulations, and confidentiality requirements is the responsibility of each Area PRCO. Each IHS employee, unless otherwise authorized, is responsible for limiting access to patient medical information to strictly direct need to know in the provision of patient care. On-line Web access request form and necessary guidance for accessing the FI data system is the FI Reference Manual.

2-3.18 MEDICAL and Dental PRIORITIES

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The application of medical priorities is necessary to ensure that appropriated IHS/PRC funds are adequate to provide services that are authorized in accordance with IHS approved policies and procedures. See PRC Web site: https://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care

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2-3.19 DEFERRED SERVICES

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1. Deferred Services. Deferred Services are services that fall within IHS Medical Priorities but are not prioritized to warrant immediate authorization. Authorization for services that fall within but do not meet medical priorities may be deferred for future authorization rather than be denied as long as the services have not been provided. The service deferred must be elective (i.e., "deferrable"), not emergent or urgent. The patient must have accessed the IHS health care system during the FY. Deferred services are considered and reported by IHS as unmet need.

2. Recording and Reporting. IHS evaluates and estimates need and the unmet need for the PRC program based upon information submitted per the annual unmet need request memo and tables, see Manual Exhibit 2-3-O, by Area PRC Officers, voluntarily submitted data by Tribal PRC programs and FI payment data for the average cost for inpatient admissions, outpatient visits and patient travel. This data is needed and used to accurately determine PRC financial needs and support program budget justifications to the HHS, OMB and Congress. The reporting formats and

guidelines for deferred services accrued and deferred services expenditures are sent to the Areas on an annual basis.

3. The formula used to estimate the need is as follows, the percentages used to illustrate the formula do not remain the same year to year and are dependent upon the number of Tribes that manage PRC funds through Title I and Title V contracts. Annually the FI provides the percentage of PRC funds expended for inpatient admissions (e.g., 38%), outpatient visits (e.g., 51%) and patient transportation (e.g., 11%) and the average cost per claim of an inpatient admission (e.g., $9,863), outpatient visit (e.g., $545) and patient transport (e.g., $2,161). For illustration purposes, the IHS manages 42% of the PRC budget and Tribes manage 58%. The methodology in the table below is used to estimate the unmet need in PRC.

Unmet Need Methodology	Total Programs	Number of Programs that Reported Data	Percent of Programs that Reported Data	Percent of PRC Budget Accounted for	Apply Percent of Data Reported
Federal PRC Programs	67	67	100%	42%	42%
Tribal PRC Programs	177	68	38%	58%	22%
		Percent of Data Reported			64%
		Percent of Data Not Reported			36%

4. *Estimated Number of Denied Services = (Reported Number of Denied Services / Percent of Data Reported) * (Percent of Data Not Reported)

5. **Cost for the Estimated Number of Denied Services = Average Cost per Claim (as provided by the FI) * Estimated Number of Denied Services

2-3.20 PURCHASED/REFERRED CARE REVIEW COMMITTEE

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The PRC review committee function is to review PRC referred care and notifications regarding emergency episodes of care and to determine medical priority and rank based on relative medical need within the same medical priority level. Utilizing Area guidelines, the PRC review committee will monitor high cost cases including the progress of each case.

The IHS will maintain a PRC review committee to review and prioritize PRC referrals and notifications regarding emergency episodes of care based on Medical Priorities of Care, as well as to review and monitor the referral and expenditure of PRC funds.

1. PRC Review Committee Requirements.

   The following elements along with PRC staff will be maintained by all PRC Review Committees:

   1. Defined policies and procedures regarding the PRC referral process will include: Referral tracking methodology noting the disposition of each referral reviewed; and meeting notes summarizing decisions and activities of each meeting. Records will be maintained and made available for review as requested by IHS officials.

   2. Committee membership shall consist of the Clinical Director, or his or her designee and others, i.e., utilization review nurse or care coordinator/case manager, patient benefit coordinator and the PRC Specialist. Membership may change periodically based on local needs, medical staff members can serve a rotation.

3. A committee member will record committee comments, medical priority and ranking information and communicate to PRC staff for referral data entry, issuance of purchase orders, denials, deferrals and notification requirements.

2. Meetings. Meetings must be held at least once a week to determine the medical priority and rank of referral requests for expenditure of PRC funds. Minutes will be maintained to accurately reflect decisions and actions for each case discussed.

3. Managing PRC Referrals and Payment Authorizations for Family Members and Relatives

    1. PRC Review Committee members are required to recuse themselves from referral, case/care discussions and decisions involving services for family members or relatives. Meeting records will include documentation indicating the reason the committee member was recused.

    2. An IHS employee with procurement authority is prohibited from signing the purchase delivery order for a family member or relative.

    3. For the purposes of this section, the IHS will use the following definition of family/relative. Family/relative means and includes the following:

    4. An individual who is related to the IHS employee as father, mother, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in- law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half-sister.

4. Criteria for Payment Decisions. The committee will consider the following criteria, at a minimum, for PRC cases:

    1. The patient must be PRC eligible.

    2. The care must be within medical priorities.

    3. The requested service is not available in an accessible IHS or Tribal facility.

    4. Funds must be available.

        1. When Funds are not available, PRC referrals must still be ranked within medical priorities by the committee.

        2. Obligation of PRC funds for a referral when no funds are available is a violation of the Anti-Deficiency Act. Federal employees who violate this act are subject to administrative and penal sanctions. Administrative sanctions may include suspension from duty without pay or removal from office. In addition, the offender(s) may also be subject to fines, imprisonment, or both.

    5. PRC referrals can then be authorized to the weekly spending limit after which all others must be deferred or denied.

    6. Care must not be deferred for cases where full reimbursement through alternate resources is available.

5. Minutes. Minutes to accurately reflect decisions and actions for each case discussed of each committee meeting and will be maintained to accurately reflect the determination of each case.

6. High Cost Cases. The PRC review committee will monitor high cost cases, including the progress of each case, utilizing current Area/Tribal guidelines for high cost case management.

2-3.21 PROMPT ACTION ON PAYMENT OF CLAIMS ALSO KNOWN AS THE PRC "FIVE-DAY RULE"

1. Time of Response. 25 U.S.C. 1621s requires the IHS to respond to a notification of a claim by a provider of a PRC service with either an individual purchase order or a denial of the claim within 5 working days after receipt of such notification. For the purposes of this rule the following definitions apply.

2. Notification of a Claim.

~~2.~~1. For the purposes of 42 CFR part 136, and also 25 U.S.C. 1621s and 1646, the submission of a claim that meets the requirements of 42 CFR 136.24. In nonemergency cases, a sick or disabled Indian, an individual or agency acting on behalf of the Indian, or the medical care provider shall, prior to the provision of medical care and services notify the appropriate ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility.

~~1.~~ The requirement for notice prior to providing medical care and services under this paragraph may be waived by the ordering official if: (1) Such notice and information are provided within 72 hours after the beginning of treatment or admission to a health care facility; and (2) The ordering official determines that giving of notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.~~Such claims must be submitted within 72 hours after the beginning of treatment for the condition or after admission to a health care facility notify the appropriate ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services.~~

2. The information submitted with the claim must be sufficient to:

~~1. Identify the patient as eligible for IHS services (e.g., name, address, home or referring service unit, Tribal affiliation),~~

~~2.~~1. Identify the medical care provided (e.g., the date(s) of service, description of services), and

~~3.~~2. Verify prior authorization by the IHS for services provided (e.g., IHS purchase order number or medical referral form) or exemption from prior authorization (e.g., copies of pertinent clinical information for emergency care that was not prior-authorized).

3. To be considered sufficient notification of a claim, claims submitted by providers and suppliers for payment must be in a format that complies with the format required for submission of claims under title XVIII of the Social Security Act (42 U.S.C. 1395 *et seq.*) or recognized under section 1175 of such Act (42U.S.C. 1320d-4).

3. Failure to Timely Respond. If IHS fails to respond to a notification of a claim as defined in 2-3.21A, IHS shall accept the claim as a valid claim for PRC services.

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4. Time of Payment. The Service shall pay a completed contract care service claim within 30 days after completion of the claim, in accordance with the Prompt Payment Act 31 U.S.C. 3901 (See Manual Exhibit 2-3-P).

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2-3.22 NO PATIENT LIABILITY

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The Affordable Care Act, enacted on March 23, 2010, reauthorized and amended the IHCIA. The IHCIA [25 U.S.C. 25 Â§ 1621~~(us)~~], provides that patients are not liable for payment of services authorized and approved for payment under a PRC program, which pays for authorized PRC referrals for healthcare services to non-IHS providers.

Section 222 of the IHCIA [25 U.S.C. Â§ 1621u] provides:

1. No Patient Liability. A patient who receives PRC services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

2. Notification. The Secretary shall notify a contract care provider and any patient who receives PRC services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than five business days after receipt of a notification of a claim by a provider of contract care services.

3. No Recourse. Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 220(b), 42 U.S.C. § 1621s(b), the provider shall have no further recourse against the patient who received the PRC services.

In summary, a patient is not liable for services that have been authorized for payment by a PRC program carried out by the IHS or a Tribal health program. Providers are prohibited from collecting any payments for these services from the patient, whether directly or through referral to an agent for collection. Please note that not all visits or referrals of IHS eligible patients to non-IHS providers are authorized for payment.

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A sample letter to be sent to patients and providers informing them that patients are not liable for payment of services authorized and approved for payment under a PRC program can be found in Manual Exhibit 2-3-Q.

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2-3.23 THIRD-PARTY TORTFEASOR CASES AND FMCRA

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1. Definition. Third-party tortfeasor cases are cases where IHS provides or pays for services to an injured individual where a third-party (the Tortfeasor) may be found to be responsible for the injury. See IHS Circular No. 2006-02, "Reporting Third-Party Tortfeasor Claims and Recovery of Funds under the Federal Medical Care Recovery Act".

2. Claims. Under the FMCRA the Government is authorized to recover the cost of these services. The various offices of the Regional Attorney are responsible for asserting any Government claim under the FMCRA. Payment is not to be withheld pending final determination of any claim the patient may have against a third party.

3. Alternate Resource. Authorization of PRC may not be denied based on any theory that potential recovery from an alleged third-party tortfeasor constitutes an "alternate resource" under the PRC regulations.

4. Recovery. Any recovery made by the government must go back to the respective PRC Program. The reporting and payment requirements are mandatory and must be followed.

5. Cost of Services Settlement. Failure to report FMCRA cases could possibly harm the patient or the patient's family. If the injured party should make a settlement that does not reflect the cost of

services provided by the IHS, the Government might still have claim against the settlement for the cost of services. Though whether the Government may or may not pursue a claim in such a situation, the possibility cannot be ruled out. Therefore, prompt reporting can act to protect the interest of the injured party.

6. Third-Party Report Forms. All third-party report forms should be completed by the facility staff as indicated by local policy and contain the following information:

    1. Patient Name
    2. Date of Service, explanation of situation
    3. Name of third party, which may be responsible for payment in the case
    4. Costs paid by IHS
    5. Any related correspondence

Manual Exhibit 2-3-F

NOTICE TO PURCHASED/REFERRED CARE PROVIDERS CONCERNING ALL PATIENTS BEING REFERRED BY THE INDIAN HEALTH SERVICE

A patient may be referred by an authorizing official of the Indian Health Service (IHS) when the medical care required cannot be provided at the IHS facility. The referral is not an implication that the IHS will authorize payment for the cost of the care to be provided. The IHS will assume financial responsibility for referrals if the patient is eligible within a Purchased Referred Care Delivery Area under the Purchased/Referred Care (PRC) regulations and is not eligible for or does not have an alternate resource. Patients who are ineligible under the PRC regulations will be financially responsible for the medical costs incurred for a referral made by the IHS.

The basic criterion for determination of an Indian person's eligibility for the PRC program is contained in the PRC regulations 42 Code of Federal Regulations. Generally, Aan Indian person is deemed eligible for PRC when heis/she resides on a Federally-recognized Indian reservation; or resides near the reservation of which he/she is a member; or it ihas been determined that he/she to hasve close social and economic ties with the Tribes located on the reservation.

Further clarification and/or additional information concerning PRC may be obtained from the Chief Executive Officer and/or the Supervisory Health Systems Specialist, PRC.