INDIGENOUS PACT

Final Rule--Purchased/Referred Care (PRC) Rates

Learn how last year's final rule on Purchased Referred Care increases flexibility to negotiate Medicare-like rates to secure provider contracts.

On March 21, 2016, the Department of Health and Human Services (HHS) via the Indian Health Service (IHS) finalized Rule 42 CFR Part 136, referred to as the "Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated With Non-Hospital-Based Care." The rule was made effective May 20, 2016, and newly contracted rates must be implemented by March 21 of 2017. Tribes are not required to participate, but rather given the option to "opt-in" by the implementation date.

In summary, the final rule allows the IHS, Tribes, Tribal organizations, and urban Indian organizations (I/T/Us) to apply Medicare payment methodologies to all physician and clinician non-hospital-based services. Mainly, the rule will allow tribes the ability to negotiate with non-tribal providers based upon standard Medicare rates. Additionally, IHS has granted tribes the flexibility to negotiate rates above Medicare-like rates to secure network contracts. Covered services include outpatient care, physician care, laboratory testing, dialysis, radiology, pharmacy, and transportation (ambulance).

The Why

Access to appropriate healthcare is critical within the American Indian and Alaskan Native (AI/AN) population. AI/ANs are at a significantly higher risk of heart disease, cancer, unintentional injuries (accidents), diabetes, stroke, obesity, substance abuse, sudden infant death syndrome (SIDS), teenage pregnancy, liver disease, hepatitis, and other mental health related issues. However, IHS provided services are often restricted to the primary care/clinic setting despite the population's need for specialty care.

To curb this issue, IHS has afforded tribes the ability to refer care to non-tribal organizations under the Purchased/Referred Care (PRC) program. Although this program has improved AI/ANs' access to additional services, the demand for such contracted services has far exceeded the available funds. IHS funds are appropriated and capped by Congress, often causing tribes to ration care to their members. In FY 2013 alone, IHS and PRC programs denied approximately $760,855,000 for an estimated 146,928 contract care services needed by eligible beneficiaries (CFR 42 - 14978). Another reality is that tribes often possess little purchasing power when contracting with providers. Since tribes are unable to promise a large volume of referrals, providers simply lack the economies of scale that would incentivize contracting with tribes. This lack of scale has cornered tribes into offering significantly higher provider reimbursement rates than Medicare-like rates.

To avoid such shortfalls of care, the final rule caps provider contract rates at established Medicare-like rates. By doing so, IHS believes that tribes will be able to extend their allotted PRC funds further. However, one immediate fear held by many tribes is that most providers simply will not take on tribal members for lower rates. IHS addressed this concern by allowing tribes the flexibility to contract above Medicare-like rates, or to the amount the provider or supplier accepts from its most favorable customer (MFC) (CFR 42 - 14978). Additionally, IHS suggests that tribes drive volume to small, well-defined networks to incentivize provider engagement. Ultimately, though, there is no guarantee that providers will accept these new contracts, especially since the billing and reporting hurdles within Indian health continue to rise.

How Indigenous Pact can help

One of Indigenous Pact's primary goals is to increase tribal reimbursement and access to care. The March 20th rule provides a unique opportunity for the Pact to deploy its expertise in billing, reimbursement, and network contracting. Although IHS has secured the ability to increase the potential scope of AI/AN healthcare delivery, the new framework heavily depends on upon the tribes contracting capabilities. Even with the capacity to contract above Medicare-like rates, tribes will need assistance in building a willing and able provider network. The most obvious option, as noted by IHS, is driving volume through narrow networks. By curating member adherence to the network, providers can operate profitably within Indian health.

It is important to note, though, that network contracting is only a piece of the overall problem. Providers find themselves jumping through administrative hoops in order to receive any reimbursement. The Pact works with providers on behalf of the tribes to ensure providers are properly reimbursed for all covered services. Moreover, PRC funds are one of many buckets of funding for the native peoples. The Pact is hard at work stitching together all of the government funding programs afforded to the native peoples, allowing tribes to exhaust all other reimbursement avenues before using their limited PRC funds.

Final Thoughts

In the end, the final rule provides tribes yet another opportunity to secure additional healthcare reimbursement. To fully realize the opportunity, tribes must think dynamically about their PRC network and all of its moving parts. By leveraging the skill sets of Indigenous Pact, tribes can confidently construct a provider network, ensure payments to providers, and extend the reach of their PRC funds.