Questions for the Record

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Committee on Natural Resources Subcommittee on Indian and Insular Affairs
Legislative Hearing

H.R. 2687 (Rep. Peltola), To amend the Alaska Native Claims Settlement Act to exclude certain payments to aged, blind, or disabled Alaska Natives or descendants of Alaska Natives from being used to determine eligibility for certain programs, and for other purposes; and

H.R. 7516 (Rep. Johnson of SD), "Purchased and Referred Care Improvement Act of 2024."

Questions from Chairman Westerman:

1. Your written statement indicated that H.R. 7516 should apply to both direct service and tribal run PRC programs. Are you aware of any complaints regarding how PRC programs operate under a tribally operated health program?

Response: The Indian Health Service (IHS) is not aware of any specific complaints regarding tribally operated Purchased/Referred Care (PRC) programs. We suggested the inclusion of a Tribal Health Program in the amendments made to section 222(a) of the Indian Health Care Improvement Act (25 U.S.C. 1621u(a)) to clarify that all IHS patients, regardless of whether they receive PRC services through an IHS or tribally-operated facility, are covered by the patient liability protections contained within the provisions. We fully support tribal sovereignty and tribes' inherent right to operate their PRC programs accordingly. When tribes elect to operate a PRC program, they may choose to adopt policies that differ from those of IHS-operated PRC programs. As such, the operational amendments made to subsection (d) of that Act should reflect that procedures established and implemented by IHS may be different from the procedures established and implemented by tribal PRC programs.

If Congress intends to focus exclusively on IHS operated PRC programs under (d), this would at least appear to treat PRC patients differently. We hope and anticipate that no PRC patients would need to use the process set forth under (d) of the bill, but if any PRC patient would need it, it is unclear why it would only be available to those served by IHS operated PRC programs. Furthermore, IHS would not have the funding to pay for patients of tribally operated PRC programs under (d), since that funding has been transferred to the tribally operated PRC programs under the Indian Self-Determination and Education Assistance Act. Regardless of how Congress intends to proceed with (d), we would like to reemphasize the importance of clarifying the protections for all PRC patients, as well as the role of all PRC programs, under (a)-(c).

a. Please provide further clarification on how H.R. 7516 may impact IHS and Tribal Health Programs differently.

As explained above, when tribes elect to operate a PRC program, they may choose to adopt policies that differ from those of IHS-operated PRC programs. As such, the operational amendments made to subsection (d) of that Act should reflect that procedures established and implemented by IHS may very well be different from the procedures established and implemented by tribal PRC programs.

2. Most of the issues regarding the PRC program revolve around the lack of response from the IHS and the IHS's lack of transparency on the process by which PRC bills are paid to providers. Your written statement indicated that in June 2022, the HHS Office of Inspector General closed the seven open recommendations to improve the PRC program from their April 2020 report.

a. What metrics can IHS provide to the committee that show what, if any, improvements have happened since those recommendations were closed?
The IHS has been actively analyzing and striving to improve the Fiscal Intermediary (FI) payment process. The FI is a contracted service through Blue Cross and Blue Shield of New Mexico that serves as the payment mechanism for PRC providers to seek reimbursement for services rendered to our beneficiaries. The IHS meets with the FI twice per month for updates on claim processing and analysis. On average, the FI pays "clean" claims within 18-20 days of receipt. Clean claims represent claims that are without errors or rejections and are processed and paid without any need for follow-up.

One area of focus for the IHS and the FI has been "pended claims." An analysis done by the IHS in December 2023 identified concerns with the number of "pended" claims at the FI resulting in delays in payment. These "pended" claims are not "clean", indicating a potential issue with the IHS purchase order or the PRC provider's claim (such as alternate resource documentation, complete claim information, etc.) that prevents payment of the claim.

The IHS worked with the FI to develop a new reporting tool to enhance end user application and functionality to address the pended claim issue. The new reporting tool became available in March 2024 and has served as a catalyst for decreasing the number of pended claims. Since March 2024, the IHS has reduced the overall number of pended claims by 25%. Furthermore, the number of pended claims awaiting a vendor response has reduced by 43%. The new reporting tool has enabled the IHS to continue addressing past concerns with the FI while also conducting focused outreach to vendors with high numbers of pended claims, encouraging them to submit updated or corrected claim information. The IHS will continue to take steps to address claim accuracy and timeliness of payment.

b. Can IHS or HHS provide information regarding the "corrective actions and staff training" that have been implemented?

The IHS has continued efforts to improve the PRC program. Each IHS Area has continued to engage in hosting vendor outreach efforts both in person and via webinar. The FI has also

provided vendor outreach, and has implemented a vendor portal that allows claim research and payment information. Furthermore, on January 1, 2024, the IHS has implemented a new medical priority system that integrates all aspects of the care continuum in a balanced, evidence-based, outcome-oriented, and consistent manner. The conceptual framework embodies the principles of integrated care, recognizing the need to incorporate certain "CORE" elements in each of the four categories of care:

Preventative and Rehabilitative Services
Medical, Dental, Vision, and Surgical Services
Reproductive and Maternal Child Health Services
Behavioral Health Services

Additionally, the IHS has revised language within its referral documents to ensure that the "No Patient Liability" language from section 222 of the Indian Health Care Improvement Act (25 U.S.C. 1621u) is prominently included and repeated as needed. The referrals also provide vendors with billing guidance to facilitate payments from the FI.

3. What process does HHS and/or IHS use to ensure that providers who participate in the PRC program are educated on how the IHS and tribal health system works and on who is responsible to pay for what services?

Each IHS Area routinely conducts outreach with their vendors. The IHS has revised the referral language to clearly explain patient coverage and responsibility for payment. In addition to our response to question #2 regarding vendor education and communication, some IHS Areas have implemented wallet-sized PRC Information Cards that provide explanation of potential coverage, no liability language for authorized services, and how to send claims to the FI for processing.

a. Is there a continuing education process for private providers on the PRC program?

Yes, please see the response to questions #2 and #3 above. Each IHS Area conducts their own vendor outreach, some Areas host twice monthly calls with high volume providers. Additionally, the Division of Contract Care within the Office of Resource Access and Partnerships has held outreach efforts in collaboration with the FI and IHS Areas. Furthermore, the new FI reporting tool has enabled IHS Areas to conduct collaborative vendor outreach by identifying vendors with a high volume of pended claims at the FI.