Statement for the Record

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U. S. Department of Health and Human Services

For the Subcommittee on Indian and Insular Affairs
Committee on Natural Resources
United States House of Representatives

Legislative Hearing

H.R. 8658, Indian Health Service Emergency Claims Parity Act

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Good afternoon, Chairman Hurd, Ranking Member Leger Fernandez, and Members of this Subcommittee. Thank you for the opportunity to submit the Indian Health Service's (IHS) Statement for the Record on H.R. 8658, the "Indian Health Service Emergency Claims Parity Act."

The IHS is an agency within the Department of Health and Human Services (HHS), and our mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level. This mission is carried out in partnership with AI/AN Tribal communities through a network of over 600 Federal and Tribal health facilities and 41 Urban Indian Organizations that are located across 37 states and provide health care services to approximately 2.8 million AI/AN people annually.

The IHS was established by statute and is the principal federal health care provider and health advocate for AI/AN people. The IHS was established to carry out the responsibilities, authorities, and functions of the United States, as provided in Federal statutes and treaties to provide health care services to Indians and Indian tribes. IHS is the 18th largest health care system in the United States.

H.R. 8658, the "Indian Health Service Emergency Claims Parity Act," relates to the IHS Purchased/Referred Care Program (PRC). Our goal is to improve health outcomes for American families and protect patients from medical debt. Unfortunately, too many families across the country – including many families in Indian Country – are still saddled with crushing medical debt. This debt often forces families into making untenable decisions, between paying off the debt and purchasing lifesaving medications or putting food on the table. Medical debt is a barrier to economic mobility for working families across the country and exacerbates and contributes to existing disparities in health care by race, health, status, and income.

<u>Purchased/Referred Care Program</u>

In 1921, Congress enacted the Snyder Act, authorizing the Bureau of Indian Affairs (BIA) to provide health services to Indian tribes throughout the United States, and also contract out these health services to health care providers as needed. In 1955, the Transfer Act moved health care from BIA to the Department of Health, Education, and Welfare, the predecessor of HHS. Subsequently, those authorities have been carried out by IHS, which also operates under the authority of the Indian Health Care Improvement Act (IHCIA). The IHS receives annual lump-sum appropriations to carry out its authorities, including those under the Snyder Act and IHCIA. In January 2014, the Consolidated Appropriations Act, 2014, renamed the Contract Health Services program as the PRC program. IHS uses the PRC program to purchase health services that are not reasonably accessible or available through the IHS network.

PRC funds are used to supplement and complement other healthcare resources available to IHS-eligible American Indian/Alaska Natives — the IHS' defined service population. Because IHS appropriations do not fully fund the health care needs of the AI/AN population, the PRC program must rely on specific regulations relating to eligibility, notification, residency, and a medical priority rating system. The IHS is designated as the payor of last resort, meaning that all other available alternate resources, including Medicare, Medicaid, private insurance, state or other health programs, etc., must be billed first before the IHS will pay for healthcare services. These mechanisms enhance the IHS's ability to stretch the limited PRC dollars and are designed to extend services to more in the AI/AN community.

The Department and the IHS have worked hard to prioritize improvements to the PRC program and ensure that patients have access to accessible – and affordable – quality care. In fact, strengthening the Purchased/Referred Care Authorization and Payment Process and effectively managing PRC carryover balances was one of the top three goals of the IHS 2024 Work Plan. In June 2022, the HHS Office of Inspector General closed the seven open recommendations to improve the PRC program from the April 2020 Report[1] after the IHS implemented a multitude of corrective actions and staff trainings. Past implementation of PRC rates and Medicaid expansion have increased the PRC Program's purchasing power to provide more care for our beneficiaries.

Just over two years ago, the IHS updated the medical priority levels and issued funding guidance to support a holistic, balanced, outcome-oriented, and consistent referral priority system. This change maximizes the efficiency of resource allocation and promotes evidence-based strategies that balance the preventive, mental health, chronic, and acute care needs in our service population with the goal of improved patient satisfaction and health outcomes. This balanced approach replaced a hierarchical concept that placed a higher emphasis on acute disease complications versus providing care for chronic and disease prevention strategies. As a result, the IHS has moved to re-assign and reclassify some preventative care services to a higher priority level within the IHS medical priority levels.

The IHS implemented routine monitoring to address some of the more common and difficult issues facing PRC programs from paying timely and appropriately for authorized care. This includes addressing provider billing issues, Fiscal Intermediary pended claims, and alternate resource issues. These efforts will go a long way to improve the PRC program and benefit to our PRC-eligible population.

[1] A-03-16-03002

The IHS acknowledges that there is still more to be done. As with other programs within the IHS, staff vacancies, space limitations, and proper training of staff at some sites have negatively impacted the ability to carry out PRC goals. The IHS continues to support new strategies to develop the workforce and leverage advanced practice providers and paraprofessionals to improve the access to quality care in AI/AN communities.

H.R. 8658, Indian Health Service Emergency Claims Parity Act

The Indian Health Service Emergency Claims Parity Act would amend the Indian Health Care Improvement Act to specify the notification requirement for individuals receiving emergency PRC who are not either elderly or disabled. The current statute, section 406 of the Indian Health Care Improvement Act (25 U.S.C. 1646), specifies a timeframe only for elderly and disabled individuals. Individuals receiving emergency PRC who are not elderly or disabled must generally provide notification within 72 hours, per current PRC regulation (see 42 CFR 136.24(c)). Under this same regulation, the 72-hour period may be extended when notification within the prescribed period was impracticable or other good cause existed for failure to comply. If the individual is elderly or disabled, under existing law, section 406 of the Indian Health Care Improvement Act (25 U.S.C. 1646), the notification timeframe for such individual is within 30 days.

The only concern with H.R. 8658 is a typo in the introduced version of the legislation. We recommend deletion of "be" on page 2, line 17. Compared to similar legislation, H.R. 8658 included a provision providing flexibility in prospective implementation. Specifically, "the time limitation for notifying the Service of such treatment or admission shall *not be less than* 15 days" (emphasis added). Thus, the language would provide the flexibility to continue exceptions for good cause on a case-by-case basis under PRC regulation, when notification within the 15-day period is impracticable or other good causes exist.

All things considered, the Department shares the same goal as the drafters – to improve the PRC program, protect patients from medical debt, and ensure that American Indians and Alaska Natives throughout Indian Country have access to high quality and affordable care. We look forward to continuing our work with Congress on this bill, and as always, welcome the opportunity to provide technical assistance as requested by the Committee or its members.

Thank you again for the opportunity to submit this Statement for the Record. HHS is committed to working closely with tribal communities and other external partners and understands the importance of working together to address the needs of American Indians and Alaska Natives.