Testimony

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation
Department of Health and Human Services

Legislative Hearing before the
House of Representatives
House Natural Resources Subcommittee on Indian and Insular Affairs

H.R. 7516, the ''Purchased and Referred Care Improvement Act of 2024''

April 30, 2024

Good afternoon Chair Hageman, Ranking Member Leger Fernandez, and Members of the Subcommittee. Thank you for the opportunity to provide testimony on an important legislative proposal before your Committee, and for your continued support for the efforts of the Department of Health and Human Services (HHS or Department) to improve the health and well-being of American Indians and Alaska Natives (AI/AN). Your consideration today of Congressman Johnson's *Purchased and Referred Care Improvement Act of 2024* underscores that commitment to improving the quality of life in Indian Country.

I am Melanie Anne Egorin, the Assistant Secretary for Legislation (ASL) at HHS. My office serves as the primary link between the Department and Congress. The Office of the ASL provides technical assistance on legislation to members of Congress and their staff, facilitates informational briefings from Department programs that support policy development by Congress, and supports implementation of legislation passed by Congress.

Last year, I was honored to visit the Lakotan lands in South Dakota as part of the Secretary's Tribal Advisory Committee and had an opportunity to speak to patients and providers at the Pine Ridge Hospital on the Pine Ridge reservation and the Oyate Health Center in Rapid City, South Dakota. I heard firsthand accounts about the challenges that both patients on the ground and the Indian Health Service (IHS) have faced with the Purchased/Referred Care (PRC) program. These same concerns have been echoed to the Secretary and Director Tso by a number of tribes during their travels across the country.

The Biden-Harris Administration and the Department have worked hard to lower health care costs and 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. With this in mind, President Biden issued Executive Order 14070 to Strengthen Americans' Access to Affordable, Quality Health Coverage. The Executive Order

directs the Department to examine policies and practices that help reduce the burden of medical debt on households, including efforts to explore how medical debts are collected from beneficiaries in our federal programs. This endeavor is meant to provide transparency on practices nationwide and will help inform policy options and approaches for reducing the burden of medical debt on working families and individuals across the country.

As you know, patients are not liable for PRC costs under section 222 of the Indian Health Care Improvement Act. Patients should not be forced into collections because of unpaid medical bills. American Indians and Alaska Natives – who already suffer disproportionately low life expectancies and disproportionate disease burden – should not be put at financial risk for seeking medical treatment.

Purchased/Referred Care Program

As you know, the IHS operates its mission 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 2.87 million AI/AN people annually.

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 healthcare 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 first be used 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 is 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

[1] A-03-16-03002

corrective actions and staff trainings. Recent implementation of PRC rates and Medicaid expansion have also increased the PRC Program's purchasing power to provide more care for our beneficiaries.

As of January 1, 2024, the IHS has 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 Secretary and Director Tso have also directed the IHS to implement updates to the Indian Health Manual Chapter 3, Part 2 Purchased/Referred Care that will include and authorize more services, and added a "reasonable person" standard for determinations related to emergency notifications. This change will allow greater understanding if the need for emergent care is outside of the IHS system. The IHS also plans to change the general rule regarding accessibility of an IHS facility, reducing the drive time requirements from 90 minutes to 60 minutes, and change the definition of "elderly" from 65 years to 55 years – providing greater flexibility for patients. The revised policy of the Indian Heath Manual Chapter 3, Part 2 Purchased/Referred care will be completed by the summer of 2024.

The IHS has also implemented an Incident Command-Like Structure to address some of the more common and difficult issues facing PRC programs from paying timely and appropriately for authorized care. This includes 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.

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 has 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.

Ultimately, the IHS needs additional authorities and resources to build out their workforce pipeline. That is why the President's budget has included a number of proposals, dating back to fiscal year 2019, that have sought to make the IHS more competitive with other federal agencies in their hiring process and reduce systemic barriers to recruitment and retention. HHS looks forward to working with Congress on policy solutions to this effect.

H.R. 7516, Purchased and Referred Care Improvement Act of 2024

The *Purchased and Referred Care Improvement Act of 2024* would amend the Indian Health Care Improvement Act to address liability for payment of charges or costs associated with the

provision of purchased/referred care services.

HHS strongly recommends that the drafters of H.R. 7516 consider the suggested edits and comments provided as technical assistance to the bill's sponsor. Much of the suggested edits are intended to clarify the application of provisions in H.R. 7516 and ensure that the statute continues to apply to all PRC programs, regardless of whether the PRC program is operated by the IHS or a Tribal Health Program. This ensures protections for patients of all PRC programs.

This bill also proposes adding a new subsection (d) to section 222 of the Indian Health Care Improvement Act, and the Department's edits here account for other applicable authorities, such as the payer of last resort statute. Simply put, a patient should not be expected to pay out-of-pocket for PRC-authorized services, due to the existing patient protections in section 222, but if patients choose to do so in anticipation of reimbursement under this new subsection (d), they will need to be careful not to pay before alternate resources or in excess of PRC rates. Thus as drafted, the bill may cause additional uncertainty for patients seeking care. Additionally, the Department has suggested a change to the timeline specified in subsection (d). While the IHS believes 30-day timeline may be challenging to implement and impractical on an administrative level, PRC program should be able to accomplish this within 45 days.

In the overwhelming majority of cases, the PRC payment should occur between the PRC program and the PRC provider. As noted, the Department is concerned that there may be unintended effects of this statutory change on patients – that the bill may make the reimbursement process more confusing and difficult. Specifically, we are concerned that patients might make payments to a provider when it is not necessary, or in amounts greater than would be required. This could quickly undermine the purpose of the statute and expose these patients to financial harm, rather than protecting them from liability. The IHS would seek to educate patients on this issue, but suggests that the drafters consider potential adverse consequences in this regard.

For the Committee's situational awareness, the Department also notes while the statute presently prohibits a provider from seeking payment from a patient, the IHS consistently witnesses that this not being followed by bad actors. IHS notes that there are no consequences included in the proposed bill for a provider, debt collector, or any other person who violates this provision. Additionally, when a violation occurs, there can be impacts to the patient's credit that are not easy for the patient or the IHS to resolve.

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 testify today, and thanks again to Congressman Johnson, who has led this and many other legislative efforts to fix systemic challenges in Indian Country. 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.