ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 63

[EPA–HQ–OAR–2010–0895; FRL–9920–03–OAR]

RIN 2060–AQ11

National Emission Standards for Hazardous Air Pollutants: Ferroalloys Production; Extension of Comment Period

AGENCY: Environmental Protection Agency.

ACTION: Supplemental notice of proposed rulemaking; extension of public comment period.

SUMMARY: The Environmental Protection Agency (EPA) is announcing that the period for providing public comments on the October 6, 2014, supplemental proposed rule titled ''National Emission Standards for Hazardous Air Pollutants: Ferroalloys Production'' is being extended an additional 11 days.

DATES: The public comment period for the supplemental proposed rule published October 6, 2014 (79 FR 60238), and initially extended by 18 days on November 14, 2014 (79 FR 68152), is being extended an additional 11 days to December 19, 2014, in order to provide the public additional time to submit comments and supporting information. The EPA received a request for an extension from ERAMET Marietta, Incorporated to gather and analyze data and formulate their comments on the supplemental proposed amendments.

ADDRESSES: Written comments on the supplemental proposed rule may be submitted to EPA electronically, by mail, by facsimile or through hand delivery/courier. Please refer to the supplemental proposal (79 FR 60238) for the addresses and detailed instructions.

Docket. Publicly available documents relevant to this action are available for public inspection either electronically at *http://www.regulations.gov* or in hard copy at the EPA Docket Center, Room 3334, 1301 Constitution Avenue NW., Washington, DC. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. A reasonable fee may be charged for copying. The official public docket for this rulemaking is Docket No. EPA–HQ–OAR–2010–0895.

World Wide Web. The EPA Web site for this rulemaking is at *http://www.epa.gov/ttn/atw/ferroa/ferropg.html.*

FOR FURTHER INFORMATION CONTACT: Mr. Phil Mulrine, Metals and Inorganic Chemicals Group (D243–02), Sector Policies and Programs Division, Office of Air Quality Planning and Standards, U.S. Environmental Protection Agency, Research Triangle Park, North Carolina 27711; Telephone number: (919) 541–5289; Fax number (919) 541–3207; Email address: *mulrine.phil@epa.gov.*

SUPPLEMENTARY INFORMATION:

Comment Period

After considering the request received from ERAMET Marietta, Incorporated to extend the public comment period, the EPA has decided to extend the public comment period for an additional 11 days. Therefore, the public comment period will end on December 19, 2014, rather than December 8, 2014.

Dated: November 25, 2014.

Mary E. Henigin,

Acting Director, Office of Air Quality Planning and Standards.

[FR Doc. 2014–28387 Filed 12–4–14; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

42 CFR Part 136

RIN 0917–AA12

Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated With Non-Hospital-Based Care

AGENCY: Indian Health Service, HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend Indian Health Service (IHS) Purchased and Referred Care (PRC), formally known as the Contract Health Services (CHS), regulations to apply Medicare payment methodologies to all physician and other health care professional services and non-hospital-based services that are either authorized under such regulations or purchased by urban Indian organizations. Specifically, it proposes that the health programs operated by IHS, Tribe, Tribal organization, or urban Indian organization (collectively, I/T/U programs) will pay the lowest of the amount provided for under the applicable Medicare fee schedule, prospective payment system, or Medicare waiver; the amount negotiated by a repricing agent, if available; or the usual and customary billing rate. Repricing agents may be used to determine whether IHS may benefit from savings by utilizing negotiated rates offered through commercial health care networks. This proposed rule seeks comment on how to establish reimbursement that is consistent across Federal health care programs, aligns payment with inpatient services, and enables the IHS to expand beneficiary access to medical care.

DATES: Comments must be received on or before January 20, 2015.

ADDRESSES: In commenting, please refer to file code [**Federal Register** insert No.]. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://regulations.gov.* Follow the ''Submit a Comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Betty Gould, Regulations Officer, Indian Health Service, 801 Thompson Avenue, TMP STE 450, Rockville, Maryland 20852.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the above address.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to the address above.

If you intend to deliver your comments to the Rockville address, please call telephone number (301) 443–1116 in advance to schedule your arrival with a staff member.

Comments will be made available for public inspection at the Rockville address from 8:30 a.m. to 5 p.m., Monday–Friday, approximately three weeks after publication of this notice.

FOR FURTHER INFORMATION CONTACT: Carl Harper, Director, Office of Resource Access and Partnerships, Indian Health Service, 801 Thompson Avenue, Rockville, Maryland 20852. Telephone: (301) 443–1553.

SUPPLEMENTARY INFORMATION: The Consolidated Appropriation Act of 2014 signed by President Obama in January, 2014, adopted a new name, Purchased/Referred Care (PRC), for the CHS program. The name change was official with passage of the FY 2014 appropriation. The new name better describes the purpose of the program funding, which is for both purchased

care and referred care outside of IHS. The name change does not change the program, and all current policies, practices, will continue and is not intended to have any effect on the laws that govern or apply to CHS. IHS will administer PRC in accordance with all laws applicable to CHS. This proposed rule will use the term PRC. For the purposes of this rule, the terms provider of services (or ''provider'') and supplier have the same meaning as the terms defined at 42 U.S.C. 1395x.

I. Background

This proposed rule would amend the IHS medical regulations at 42 CFR part 136 to apply Medicare payment methodologies to all physician and other health professional services and non-hospital-based services provided through Contract Health Services (CHS), now Purchased Referred Care (PRC), or purchased by urban Indian organizations, and that are not otherwise subject to Medicare payment rates by law. Under 42 CFR 136.23, when necessary health services are not reasonably accessible or available to IHS beneficiaries, the IHS and Tribes are authorized to pay for medical care provided to IHS beneficiaries by non-IHS or Tribal, public or private health care providers, depending on the availability of funds. Similarly, under section 503 of the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. 1653, urban Indian organizations may refer eligible urban Indians, as defined under section 4 of the IHCIA, to non-I/T/U public and private health care providers and, depending on the availability of funds, may also cover the cost of care.

Sec. 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) authorized the Secretary to establish a payment methodology, payment rates, and admissions practices for Medicare-participating hospitals that furnish inpatient services applicable when such hospitals provide to an eligible American Indian/Alaskan Native (AI/AN) beneficiary medical care authorized by an I/T/U. As implemented in 42 CFR part 136 subpart D, Medicare-participating hospitals, including Critical Access Hospitals (CAHs), are reimbursed by I/T/Us using ''Medicare-like'' rates that generally correspond to the applicable Medicare payment methodology for the medical service. In instances where Medicare-participating hospitals furnish inpatient services, but are exempt from Medicare's Prospective Payment System (PPS) and receive reimbursement based on reasonable costs (for example, CAHs, children's hospitals, cancer hospitals, and certain other hospitals reimbursed by Medicare under special arrangements), payment is made per discharge based on the reasonable cost methods established under 42 CFR part 413, except that the interim payment rate, under 42 CFR part 413 subpart E, constitutes payment in full for authorized charges. Notwithstanding, if an amount has been negotiated with the hospital or its agent by the I/T/U, the I/T/U will pay the lesser of the amount determined under the PPS or the amount negotiated with the hospital or its agent.

The Medicare-like rate methodology established by 42 CFR part 136 subpart D does not apply to non-hospital services, including physician and other health professional services, services provided by a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice, or other non-hospital-based items and services. Rather, I/T/Us reimburse for authorized services at the rates provided by contracts negotiated at the local level with individual providers or according to a provider's billed charges. Given the small market share of individual I/T/U programs, I/T/Us historically have paid rates in substantial excess of Medicare's allowable rates or rates paid by private insurers for the same services. Despite establishing medical priorities to cover the most necessary care, IHS is still unable to provide care to all of its beneficiaries. The demand for PRC care consistently exceeds available funding. IHS recently reported to Congress that IHS and tribal PRC programs denied an estimated $760,855,000 for an estimated 146,928 contract care services needed by eligible beneficiaries in FY 2013.[1]

Based on an audit of fiscal year 2012, the Government Accountability Office (GAO) estimated that, by implementing a Medicare-like rate methodology, the IHS PRC programs could have saved $32 million on physician services alone, not including additional savings for other non-hospital services, or savings accrued to Tribal PRC programs. Government Accountability Office, *Indian Health Service: Capping Payment Rates for Non-Hospital Services Could Save Millions of Dollars for Contract Health Services* (April 2013) (''April 2013 Study''). The GAO concluded that by setting PRC physician and other non-hospital payments at rates consistent with Medicare and other Federal agencies, the IHS could expand IHS beneficiary access to care. These findings and recommendations are substantiated by a report from the Department of Health and Human Services' Office of the Inspector General. Department of Health and Human Services, Office of Inspector General, *IHS Contract Health Services Program: Overpayments and Potential Savings* (Sept. 2009).

II. Provisions of the Proposed Rule

This proposed rule is promulgated pursuant to 42 U.S.C. 2001(b), which provides that the Secretary ''[i]n carrying out [her] functions, responsibilities, authorities, and duties under [the Transfer Act] . . . is authorized, with the consent of the Indian people served, to contract with private or other non-Federal health agencies or organizations for the provision of health services to such people on a fee-for-service basis or on a prepayment or other basis'' and pursuant to 42 U.S.C. 2003, which authorizes the Secretary to promulgate regulations to carry out the Transfer Act. It amends the IHS regulation at 42 CFR part 136 by adding a new subpart I that applies ''Medicare-like'' rate payment methodologies to all physicians and health care professional services and all non-hospital-based services that are not covered currently under 42 CFR part 136 subpart D. The proposed rule is similar to payment methodologies promulgated in other Federal health care programs, including the Department of Veterans Affairs, by applying a consistent reimbursement policy across Federal health care programs. The proposed rule provides that the I/T/U will pay the lowest of the amount provided under the applicable Medicare fee schedule, prospective payment system, or Medicare waiver; the amount negotiated by a repricing agent,[2] if available; or the usual and customary billing rate. In the absence of a Medicare rate or Medicare waiver, or agreement, payment will be made at the amount that the provider or supplier bills the general public for the same service. The rule specifies the circumstances in which a non-hospital health care provider or supplier will be deemed to have accepted the rates established herein.

The rule caps the rate that I/T/Us are authorized to pay non-I/T/U health care providers and suppliers for services and leaves no discretion for the I/T/U and the health care provider to negotiate higher rates. The IHS recognizes this

[1] *See* Congress FY 2015 Congressional Justification Purchased/Referred Care Program Description and Accomplishments page 92–95, available online at: *http://www.ihs.gov/budgetformulation/congressionaljustifications/*.

[2] A repricing agent discounts rates charged by a health care provider to rates that the agent may have established with the health care provider as a condition of participating in the agent's provider network.

constraint could impact the delivery of patient care, particularly in circumstances where the I/T/U cannot find a health care provider or supplier willing to accept the payment rates established herein or the patient receives emergency services from a provider or supplier that refuses to accept the rate. Under 25 U.S.C. 1621u, a patient who receives authorized contract care may not be held liable for the payment of any charges. If the medical provider or supplier does not agree to accept the payment rate as payment in full, the I/T/U is effectively precluded from authorizing the care or paying the health care provider or supplier for services rendered to a beneficiary. In such circumstances, the I/T/U will not authorize payment and the patient may be held financially responsible by the provider or supplier of care for the charges. The IHS also notes that, while Medicare-participating hospitals are required to accept payment rates set forth in 42 CFR part 136 subpart D for facility services, subpart D does not apply to the professional service provided by a physician or practitioner through the hospital. To the extent the physician or practitioner does not agree to accept the rates established by this regulation, the I/T/U will not authorize payment for the service. The IHS seeks comment on whether exceptions should be incorporated into the rule to permit an I/T/U to pay in excess of the calculated rate in circumstances where it may be appropriate for the I/T/U to retain more flexibility over the payment rate. For example, a specialist that does not accept reduced rates and to access this specialty at a reduced rate it is located in another State. The travel costs and burden on the patient is too great to access the needed specialty care.

The proposed rule also specifies that payments made in accordance with the described methodology shall constitute payment in full and that, in accordance with 25 U.S.C. 1621u, the provider, supplier or their agent, may not impose additional charge on an individual for I/T/U authorized items and services. Consistent with IHS regulations, the rule further provides that, if an I/T/U has authorized payment for PRC services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payer, the I/T/U shall be the payer of last resort in accordance with 25 U.S.C. 1623(b). If there are any third party payers, the I/T/U will pay the amount for which the patient is being held responsible after the provider or supplier of services has coordinated benefits and all other alternate resources have been considered and paid, including applicable co-payments, deductibles, and coinsurance owed by the patient. For purposes of the payment methodology specified in § 136.30(a), required co-payments, deductibles, and coinsurance are those that would have been owed by a Medicare beneficiary under the proposed methodology. Because the patient may not be held liable for the payment of costs or charges under 25 U.S.C. 1621u, the I/T/U will assume these costs to the extent all payments made by any payer, do not in aggregate, exceed the maximum payment rate set forth § 136.201(a).

III. Collection of Information Requirements

These regulations do not impose any new information collection requirements. The requirements for submitting a claim are currently approved under Office and Management and Budget approval number 0917–0002, IHS Contract Health Services Report (Expires: 02/28/2016). Providers and suppliers will not be required to update information technology systems as a result of the provisions of this proposed rule. Claims will be re-priced by the IHS Fiscal Intermediary or the appropriate Tribal administrator according to the methodology adopted herein.

IV. Regulatory Impact Statement

The IHS has examined the impact of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, and the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). The April 2013 Study released by the GAO found that if federal PRC programs had paid Medicare rates for physicians services in 2010, they could have realized an estimated $32 million in annual savings to pay for additional services. Although the analysis did not include other types of non-hospital services or funding that goes to tribal PRC programs, the increase in purchasing power brought about by this proposed rule would be unlikely to exceed $100 million annually. OMB has determined that this is a significant regulatory action under Executive Order 12866.

The Secretary hereby proposes to certify that this proposed rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601 through 612. The proposed rule will not cause significant economic impact on health care providers, suppliers, or entities since only a small portion of the business of such entities concerns IHS beneficiaries. The April 2013 Study released by the GAO found that of the physicians sampled, the PRC program represented a small portion of their practice and was not a significant source of revenue. Although the sampling of physicians was small, all of the sampled physicians were in the top 25% in terms of volume of paid services covered by PRC. IHS believes the sample to be representative of higher volume practitioners currently providing services paid for by PRC. Accordingly, pursuant to 5 U.S.C. 605(b), the proposed rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

In addition, section 1102(b) of the Act requires IHS to prepare a RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, IHS defines a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. For the reasons provided above, IHS has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals. Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose requirements mandate expenditure in any one year by State, local, or Tribal governments, in the aggregate, or by the private sector, of $141 million. This proposal would not impose substantial Federal mandates on State, local or Tribal governments or private sector.

List of Subjects in 42 CFR Part 136

Alaska Natives, American Indian, Health, Medicare.

Dated: November 6, 2014 .

Yvette Roubideaux,

Acting Director, Indian Health Service.

Dated: November 18, 2014.

Sylvia M. Burwell,

Secretary, Health and Human Services.

For the reasons set forth in the preamble, the Indian Health Service proposes to amend 42 CFR chapter I as set forth below:

PART 136—INDIAN HEALTH

■ 1. The authority citation for part 136 continues to read as follows:

Authority: 25 U.S.C. 13; 42 U.S.C. 1395cc(a)(1)(U), 42 U.S.C. 2001 and 2003, unless otherwise noted.

■ 2. Add new subpart I consisting of §§ 136.201 and 136.202, to read as follows:

Subpart I—Limitation on Charges for Health Care Professional Services and Non-Hospital-Based Care

Sec.

§ 136.201 Payment for physician and other health care professional services purchased by Indian health programs and other medical charges associated with non-hospital-based care.

(a) Payment to physicians and health care professionals and all other non-hospital-based entities, for any level of care authorized under part 136, subpart C by a Purchased/Referred Care (PRC) program of the Indian Health Service (IHS); or authorized by a Tribe or Tribal organization carrying out a PRC program of the IHS under the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93–638, 25 U.S.C. 450 *et seq.;* or authorized for purchase under § 136.31 by an urban Indian organization (as that term is defined in 25 U.S.C. 1603(h)) (hereafter ''I/T/U''), shall be determined based on the applicable method in this section: The I/T/U will pay the lowest of the following amounts:

(1) The applicable Medicare payment amount, including payment according to a fee schedule, a prospective payment system or based on reasonable cost (''Medicare rate'') for the period in which the service was provided), or in the event of a Medicare waiver, the payment amount will be calculated in accordance with such waiver.

(2) An amount that has been negotiated with a specific provider or its agent, or supplier or its agent by the I/T/U or the amount negotiated by a repricing agent if the provider or supplier is participating within the repricing agent's network and an I/T/U has a pricing arrangement or contract with that repricing agent. For the purposes of this section, repricing agent means an entity that seeks to connect I/T/U with discounted rates from non-I/T/U public and private providers as a result of existing contracts that the non-I/T/U public or private provider may have within the commercial health care industry.

(3) The amount that the provider or supplier bills the general public for the same service.

(b) Coordination of benefits and limitation on recovery: If an I/T/U has authorized payment for items and services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payer—

(1) The I/T/U is the payer of last resort under 25 U.S.C. 1623(b);

(2) If there are any third party payers, the I/T/U will pay the amount for which the patient is being held responsible after the provider or supplier of services has coordinated benefits and all other alternate resources have been considered and paid, including applicable co-payments, deductibles, and coinsurance that are owed by the patient; and

(3) The maximum payment by the I/T/U will be only that portion of the payment amount determined under this section not covered by any other payer; and

(4) The I/T/U payment will not exceed the rate calculated in accordance with paragraph (a) of this section (plus applicable cost sharing); and

(5) When payment is made by Medicaid it is considered payment in full and there will be no additional payment made by the I/T/U to the amount paid by Medicaid.

(c) Authorized services: Payment shall be made only for those items and services authorized by an I/T/U consistent with part 136 of this title or section 503(a) of the Indian Health Care Improvement Act (IHCIA), Public Law 94–437, as amended, 25 U.S.C. 1653(a).

(d) No additional charges.

(1) The health care provider or supplier shall be deemed to have accepted the applicable Medicare payment amount, including payment according to a fee schedule, a prospective payment system or based on reasonable cost (''Medicare rate'') for the period in which the service was provided), as payment in full if:

(i) The services were provided based on a PRC referral authorized for payment; or,

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

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

(2) A payment made and accepted in accordance with this section shall constitute payment in full and the provider or its agent, or supplier or its agent, may not impose any additional charge—

(i) On the individual for I/T/U authorized items and services; or

(ii) For information requested by the I/T/U or its agent or fiscal intermediary for the purposes of payment determinations or quality assurance.

(e) For physicians and health care professionals and all other non-hospital-based entities required by law to accept the rates specified in this section, the applicable rate shall be the lowest of any amount calculated under paragraph (a)(1) of this section, without regard to paragraph (d)(1) of this section.

(f) No service shall be authorized and no payment shall be issued in excess of the rate authorized by this subpart.

§ 136.202 Authorization by an urban Indian organization.

An urban Indian organization may authorize for purchase items and services for an eligible urban Indian (as those terms are defined in 25 U.S.C. 1603(f) and (h)) according to section 503 of the IHCIA and applicable regulations. Services and items furnished by physicians and other health care professionals and non-hospital-based entities shall be subject to the payment methodology set forth in § 136.30.

[FR Doc. 2014–28508 Filed 12–3–14; 8:45 am]

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