

in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4);

- Does not have federalism implications as specified in Executive Order 13132 (64 FR 43255, Aug. 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and,
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, Feb. 16, 1994).

The SIP is not approved to apply on any Indian reservation land or in any other area where EPA or an Indian tribe has demonstrated that a tribe has jurisdiction. In those areas of Indian country, the rule does not have tribal implications and will not impose substantial direct costs on tribal governments or preempt tribal law as specified by Executive Order 13175 (65 FR 67249, November 9, 2000).

#### List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Carbon monoxide, Incorporation by reference, Intergovernmental relations, Greenhouse gases, Lead, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides, Volatile organic compounds.

**Authority:** 42 U.S.C. 7401 *et seq.*

Dated: January 12, 2016.

**Shaun L. McGrath,**

*Regional Administrator, Region 8.*

[FR Doc. 2016-01403 Filed 1-25-16; 8:45 am]

BILLING CODE 6560-50-P

## ENVIRONMENTAL PROTECTION AGENCY

### 40 CFR Part 63

[EPA-HQ-OAR-2015-0747; FRL-9941-59-OAR]

RIN 2060-AS13

### Oil and Natural Gas Sector: National Emission Standards for Hazardous Air Pollutants; Extension of Comment Period

**AGENCY:** Environmental Protection Agency (EPA).

**ACTION:** Request for information; extension of comment period.

**SUMMARY:** On November 27, 2015, the Environmental Protection Agency (EPA) requested information related to hazardous air pollutant emissions from sources in the oil and natural gas production and natural gas transmission and storage segments of the oil and natural gas sector. The deadline to respond to our request was January 26, 2016. In response to requests from several stakeholders, the EPA is extending the period to respond to our request for information to March 11, 2016.

**DATES:** The public comment period for the request for information published in the **Federal Register** on November 27, 2015 (80 CFR 74068), is being extended. Written comments must be received on or before March 11, 2016.

**ADDRESSES:** *Comments.* Submit your comments, identified by Docket ID No. EPA-HQ-OAR-2015-0747, to the *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the online instructions for submitting comments. Once submitted, comments cannot be edited or withdrawn. The EPA may publish any comment received to its public docket. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Multimedia submissions (audio, video, etc.) must be accompanied by a written comment. The written comment is considered the official comment and should include discussion of all points you wish to make. The EPA will generally not consider comments or comment contents located outside of the primary submission (*i.e.*, on the web, cloud, or other file sharing system). For additional submission methods, the full EPA public comment policy, information about CBI or multimedia submissions, and general guidance on making effective comments, please visit

<http://www2.epa.gov/dockets/commenting-epa-dockets>.

*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 ID No. EPA-HQ-OAR-2015-0747.

*World Wide Web.* The EPA Web site for this rulemaking is at <http://www3.epa.gov/airquality/oilandgas/actions.html>.

**FOR FURTHER INFORMATION CONTACT:** For further information about this action, contact Mr. Matthew Witosky, Sector Policies and Programs Division (E143-05), Office of Air Quality Planning and Standards, Environmental Protection Agency, Research Triangle Park, North Carolina 27711, telephone number: (919) 541-2865; facsimile number: (919) 541-3740; email address: [witosky.matthew@epa.gov](mailto:witosky.matthew@epa.gov).

#### SUPPLEMENTARY INFORMATION:

##### Comment Period

After considering the requests to extend the public comment period, the EPA has decided to extend the public comment period until March 11, 2016. This extension will provide the additional time requested by the public to review the request and gather data to respond.

Dated: January 14, 2016.

**Stephen D. Page,**

*Director, Office of Air Quality Planning and Standards.*

[FR Doc. 2016-01508 Filed 1-25-16; 8:45 am]

BILLING CODE 6560-50-P

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Indian Health Service

#### 42 CFR Part 136

RIN 0905AC97

### Catastrophic Health Emergency Fund

**AGENCY:** Indian Health Service, HHS.

**ACTION:** Proposed rule.

**SUMMARY:** The Indian Health Service (IHS) administers the Catastrophic Health Emergency Fund, The purpose of CHEF is to meet the extraordinary medical costs associated with the treatment of victims of disasters or

catastrophic illnesses who are within the responsibility of the Service. This proposed rule: Proposes definitions governing the CHEF; establishes that a Service Unit shall not be eligible for reimbursement for the cost of treatment until the episode of care's cost has reached a certain threshold; establishes a procedure for reimbursement for certain services exceeding a threshold cost; establishes a procedure for payment for certain cases; and, establishes a procedure to ensure payment will not be made from CHEF if other sources of payment (Federal, state, local, private) are available.

**DATES:** To be assured consideration, written comments must be received at the address below, no later than 5 p.m. on March 11, 2016. The IHS Area and program offices will send copies of this notice to each Tribe within their jurisdiction.

**ADDRESSES:** In commenting, please refer to file code 0905AC97. 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://www.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, Office of Management Services, Division of Regulatory Affairs, 5600 Fishers Lane, Mailstop: 09E70, Rockville, Maryland 20857.

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 one of our staff members.

Comments will be made available for public inspection at the Rockville address from 8:30 a.m. to 5:00 p.m., Monday–Friday, two weeks after publication of this notice.

**FOR FURTHER INFORMATION CONTACT:** Carl Harper, Director, Office of Resource Access and Partnerships, Indian Health Service, 5600 Fishers Lane, Mailstop:

10E85C, Rockville, Maryland 20857, Telephone (301) 443-1553.

**SUPPLEMENTARY INFORMATION:**

*Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments as soon as possible after they have been received to the following Web site: <http://www.regulations.gov>. Follow the search instructions on the Web site to view public comments.

**I. Background**

The purpose of CHEF is to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service. IHS administers CHEF to reimburse certain IHS and Tribal purchased/referred care (PRC) costs that exceed the cost threshold. Although CHEF was first established in 1988, a similar fund was authorized by Public Law 99-591, a Joint Resolution continuing appropriations for fiscal year (FY) 1987. IHS developed operating guidelines in August of 1987, which were approved by the Office of Management and Budget (OMB) for the management of CHEF. Those guidelines were developed with input from Tribal organizations and IHS personnel who work with the daily processing and management of Contract Health Services (CHS), now known as the Purchased/Referred Care (PRC) Program. Congress passed the Indian Health Care Improvement Reauthorization and Extension Act of 2009, S. 1790, 111th Cong. (2010) (IHCIREA), as section 10221(a) of the Patient Protection and Affordable Care Act, Public Law 111-148. Through IHCIREA, Congress permanently reauthorized and amended the Indian Health Care Improvement Act (IHCIA), Public Law 94-437. Section 202 of IHCIA [25 U.S.C. 1621a] establishes CHEF and directs the IHS to promulgate regulations for its administration. The operating guidelines and twenty-eight (28) years of experience (FYs 1987–2015) contributed to the design of this regulation.

**II. Provisions of This Proposed Regulation**

This regulation proposes to (1) establish definitions governing CHEF, including definitions of disasters and catastrophic illnesses; (2) establish that a Service Unit shall not be eligible for reimbursement for the cost of treatment from CHEF until its cost of treating any

victim of such catastrophic illness or disaster has reached a certain threshold cost; (3) establish a procedure for reimbursement of the portion of the costs for authorized services that exceed such threshold costs; (4) establish a procedure for payment from CHEF for cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment; and, (5) establish a procedure that will ensure no payment will be made from CHEF to a Service Unit to the extent the provider of services is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

No part of CHEF, or its administration, shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638 [25 U.S.C. 450 *et seq.*] and may not be allocated, apportioned, or delegated to a Service Unit, Area Office, or any other organizational unit. Accordingly, the IHS Division of Contract Care within the Office of Resource Access and Partnerships at Headquarters shall remain responsible for administration of CHEF.

**A. Definitions**

IHS proposes establishing the following definitions for governing CHEF, including definitions of disasters and catastrophic illnesses:

1. *Alternate Resources*—any Federal, State, Tribal, local, or private source of coverage for which the patient is eligible. Such resources include health care providers and institutions and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (*i.e.*, Medicare and Medicaid), other Federal health care programs, State, Tribal or local health care programs, Veterans Health Administration, and private insurance, including Tribal self-insurance.

2. *Catastrophic Health Emergency Fund (CHEF)*—the fund established by Congress to reimburse extraordinary medical expenses incurred for catastrophic illnesses and disasters covered by a PRC program of the IHS, whether such program is carried out by IHS or an Indian Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act.

3. *Catastrophic Illness*—a medical condition that is costly by virtue of the intensity and/or duration of its

treatment. Examples of conditions that frequently require multiple hospital stays and extensive treatment are cancer, burns, premature births, cardiac disease, end-stage renal disease, strokes, trauma-related cases such as automobile accidents and gunshot wounds, and some mental disorders. CHEF is intended to shield IHS and Tribal PRC operations from financial disruption caused by the intensity of high cost illnesses and/or events.

4. Disasters—situations that pose a significant level of threat to life or health or cause loss of life or health stemming from events such as tornadoes, earthquakes, floods, catastrophic accidents, epidemics, fires, and explosions.

5. Episode of Care—the period of consecutive days for a discrete health condition during which reasonable and necessary medical services related to the condition occur.

6. Purchased/Referred Care (PRC)—any health service that is—

(a) delivered based on a referral by, or at the expense of, an Indian health program; and

(b) provided by a public or private medical provider or hospital which is not a provider or hospital of the IHS health program.

7. Service Unit—an administrative entity of the Service or a Tribal health program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

8. Threshold Cost—the designated amount above which incurred medical costs will be considered for CHEF reimbursement after a review of the authorized expenses and diagnosis.

#### B. Threshold Cost

IHCIA section 202 provides that a Service Unit shall not be eligible for reimbursement from CHEF until its cost of treating any victim of a catastrophic illness or event has reached a certain threshold cost. The Secretary is directed to establish the initial CHEF threshold at—

(1) the FY 2000 level of \$19,000; and  
(2) for any subsequent year, the threshold will not be less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers (United States city average) for the 12-month period ending with December of the previous year.

IHS intends to set the initial threshold governed by this rule at \$19,000 for FY 2016. In reaching this determination, IHS adopted the recommendation of the IHS Director's Workgroup on Improving

PRC. The Workgroup, composed of Tribal leaders and Tribal and Federal representatives, voted 18–2 to recommend \$19,000 as the initial threshold. For this recommendation, the Workgroup considered several factors, including (1) Tribal concerns regarding the lower threshold and the potential to exhaust CHEF earlier in the FY leaving PRC programs without the ability to recover costs for treating victims of catastrophic illnesses or disasters; and, (2) Tribal concerns about setting the threshold at the FY 2000 level and then applying the CPI for each year since FY 2000, which would have resulted in a \$30,000 plus threshold requirement by FY 2013. At this higher level, PRC programs with limited budgets would be unable to access the CHEF to seek recovery for extraordinary medical costs. Accordingly, IHS intends to set the initial threshold at \$19,000 for FY 2016, with increases in subsequent years based on the annual Consumer Price Index.

#### C. Compliance With PRC Regulations

IHS proposes to follow PRC regulations 42 CFR part 136 for payment from CHEF. For example, payment or reimbursement from CHEF may be made for the costs of treating persons eligible for PRC in accordance with 42 CFR 136.23 and authorized for PRC in accordance with 42 CFR 136.24. In cases where the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service Unit, authorization must be obtained in accordance with 42 CFR 136.24(c). For example, claims for reimbursement of services provided that do not meet the 72 hour emergency notification requirements found at 42 CFR 136.24(c) will be denied. The applicable Area PRC program shall review CHEF requests for CHEF reimbursement to ensure consistency with PRC regulations.

#### D. Alternate Resources

In accordance with section 202(d)(5) of IHCIA [25 U.S.C. 1621a (d)(5)], alternate resources must be exhausted before reimbursement is made from CHEF. No reimbursement shall be made from CHEF to any Service Unit to the extent the patient is eligible to receive payment for treatment from any other Federal, State, Tribal, local, or private source of reimbursement. Medical expenses incurred for catastrophic illnesses and events will not be considered eligible for reimbursement if they are payable by alternate resources, as determined by IHS, whether or not such resources actually make payment. IHS is the payor of last resort and, if the

provider of services is eligible to receive payment from other resources, the medical expenses are only payable by PRC and reimbursable by CHEF to the extent IHS would not consider the other resources to be “alternate resources” under the applicable regulations and IHS policy. Expenses paid by alternate resources are not eligible for payment by PRC or reimbursement by CHEF. However, if the patient becomes eligible for alternate resources, the Service Unit shall return all funds reimbursed from CHEF to the Headquarters CHEF account.

#### E. Reimbursement Procedure

A patient must be eligible for PRC services and the Service Unit must adhere to regulations (42 CFR 136.23(a) through (f)) governing the PRC program to be reimbursed for catastrophic cases from CHEF. Once the catastrophic case meets the threshold requirement and the Service Unit has authorized PRC resources exceeding the threshold requirement, the Service Unit may qualify for reimbursement from CHEF. Reimbursable costs are those costs that exceed the threshold requirement after payment has been made by all alternate resources such as Federal, State, Tribal, local, private insurance, and other resources. Reimbursement of PRC expenditures incurred by the Service Unit and approved by the PRC program at Headquarters will be processed through the respective IHS Area Office. Reimbursement from CHEF shall be subject to availability of funds.

#### F. Recovery of CHEF Reimbursement Funds

In the event a PRC program has been reimbursed from CHEF for an episode of care and that same episode of care becomes eligible for and is paid by any Federal, State, Tribal, local, or private source (including third party insurance), the PRC program shall return all CHEF funds received for that episode of care to the CHEF at IHS Headquarters. These recovered CHEF funds will be used to reimburse other valid CHEF requests.

### III. Collection of Information Requirements

Prior to implementing the rule, IHS may be required to develop new information collection forms that would require approval from the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995, 44 United States Code 3507(d).

### IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not

able to acknowledge or respond to them individually. We will consider all comments received by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a final rule, we will respond to the comments in the preamble to that rule.

## V. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order (E.O.) 12866 on Regulatory Planning and Review (September 30, 1993); section 603 of the Regulatory Flexibility Act (RFA), Public Law 96-354 [5 U.S.C. 601-612], as amended by subtitle D of the Small Business Regulatory Fairness Act of 1996, Public Law 104-121; the Unfunded Mandates Reform Act (UMRA) of 1995, Public Law 104-4; E.O. 13132 on Federalism (August 4, 1999); the Congressional Review Act [5 U.S.C. 804(2)]; and E.O. 13175 Consultation and Coordination with Indian Tribal Governments.

### A. E.O. 12866

E.O. 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). In accordance with E.O. 12866, Agencies must submit a regulatory impact analysis for those regulatory actions that are “significant” within the meaning of “economically significant.” A regulatory action is economically significant if it is anticipated to “(1) have an annual effect on the economy of \$100 million or more” or (2) to “adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or Tribal governments or communities.” This rule is not being treated as a “significant regulatory action” under section 3(f) of E.O. 12866. Accordingly, the rule has not been reviewed by the Office of Management and Budget.

### B. Regulatory Flexibility Act (RFA)

RFA requires analysis of regulatory options that minimize any significant economic impact of a rule on small entities, unless it is certified that the proposed rule is not expected to have a significant economic impact on small entities. This rule is not expected to have a significant economic impact on small entities.

### C. Unfunded Mandates Reform Act (UMRA)

Section 202 of UMRA (Pub. L. 104-4) requires an assessment of anticipated costs and benefits before proposing any rule that may result in expenditure by State, local, and Tribal governments, in aggregate, or by the private sector of \$100 million in any one year. We have determined that this rule is consistent with the principles set forth in the executive orders and in these statutes and find that this rule will not have an effect on the economy that exceeds \$100 million in any one year. The IHS FY 2015 annual appropriation for CHEF was \$51.5 million. This final rule is not anticipated to have an effect on State, local, or Tribal governments in the aggregate, or by the private sector of \$100 million or more. This rule does not impose any new costs on small entities, and it will not result in a significant economic impact on a substantial number of small entities. Thus, no further analysis is required.

### D. Federalism

E.O. 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule under the threshold criteria of E.O. 13132 and have determined that this proposed rule would not have substantial direct effect on the States, on the relationship between the Federal Government and the States, or on the distribution of power and governmental responsibilities among the various levels of the government(s). As this rule has no Federal implications, a Federalism summary impact statement is not required.

### E. Congressional Review Act

This rule is not a “major rule” as defined by 5 U.S.C. 804(2)—it does not or is not likely to result in:

- (1) An annual effect on the economy of \$100,000,000 or more;
- (2) a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets. The term does not include any rule promulgated under the

Telecommunications Act of 1996 and the amendments made by that Act.

### F. E.O. 13175 Consultation and Coordination With Indian Tribal Governments

This rule has Tribal implications under E.O. 13175, Consultation and Coordination with Indian Tribal Governments, because it would have a substantial direct and positive effect on one or more Indian Tribes.

These guidelines were developed with input from Tribes and IHS personnel who work with the daily processing and management of PRC resources. The IHS Director’s Workgroup on Improving PRC met and discussed these guidelines on October 12-13, 2010, and June 1-2, 2011, in Denver, Colorado, and on January 11-12, 2012, in Albuquerque, New Mexico. Based on the recommendation of the Workgroup the threshold amount of \$19,000 is proposed to be established for the current fiscal year. This proposed rule serves as Tribal consultation with affected Tribes by giving interested Tribes the opportunity to comment on the regulation before it is finalized. In addition, IHS issued “Dear Tribal Leader” letters related to the development of these regulations on February 9, 2011, and May 6, 2013. IHS intends to consult as fully as possible with Tribes prior to the publication of a final rule.

### List of Subjects in 42 CFR Part 136

Alaska Natives, Contract Health Services, Health, Health facilities, Health service delivery areas, Indians.

Dated: November 10, 2015.

#### Robert G. McSwain,

Principal Deputy Director, Indian Health Service.

Dated: January 11, 2016.

#### Sylvia M. Burwell,

Secretary, Health and Human Services.

For the reasons set out 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 is revised to read as follows:

**Authority:** 42 U.S.C. 2001 and 2003; 25 U.S.C. 13; and 25 U.S.C 1621a.

- 2. Add new subpart L consisting of §§ 136.501–136.509 to read as follows:

### Subpart L—Indian Catastrophic Health Emergency Fund

Sec.

136.501 Definitions.

136.502 Purpose of the regulations.

136.503	Threshold cost.
136.504	Reimbursement procedure.
136.505	Reimbursable services.
136.506	Alternate resources.
136.507	Program integrity.
136.508	Recovery of reimbursement funds.
136.509	Reconsideration and appeals.

### Subpart L—Indian Catastrophic Health Emergency Fund

#### § 136.501 Definitions.

As used in this subpart:

*Alternate Resource* means any Federal, State, Tribal, local, or private source of reimbursement for which the patient is eligible. Such resources include health care providers and institutions and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (*i.e.*, Medicare and Medicaid), other Federal health care programs, State, Tribal or local health care programs, Veterans Health Administration, and private insurance.

*Catastrophic Health Emergency Fund (CHEF)* means the fund created by Congress to cover extraordinary medical expenses incurred for catastrophic illnesses and disasters covered by a purchased/referred care (PRC) program of the Indian Health Service (IHS), whether such program is carried out by IHS or an Indian Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act.

*Catastrophic Illness* refers to a medical condition that is costly by virtue of the intensity and/or duration of its treatment. Examples of conditions that frequently require multiple hospital stays and extensive treatment are cancer, burns, premature births, cardiac disease, end-stage renal disease, strokes, trauma-related cases such as automobile accidents, and gunshot wounds, and some mental disorders. CHEF is intended to shield IHS and Tribal PRC operations from financial disruption caused by the intensity of high cost illnesses and/or events.

*Disaster* means a situation which poses a significant level of threat to life or health or causes loss of life or health stemming from events such as tornadoes, earthquakes, floods, catastrophic accidents, epidemics, fires, and explosions.

*Episode of Care* means the period of consecutive days for a discrete health condition during which reasonable and necessary medical services related to the condition occur.

*Purchased/Referred Care* means any health service that is—

(1) Delivered based on a referral by, or at the expense of, an Indian health program; and

(2) Provided by a public or private medical provider or hospital which is not a provider or hospital of the Indian health program.

*Service Unit* means an administrative entity of the Service or a Tribal health program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

*Threshold Cost* means the designated amount above which incurred medical costs will be considered for CHEF reimbursement after a review of the authorized expenses and diagnosis.

#### § 136.502 Purpose of the regulations.

(a) The Indian Catastrophic Health Emergency Fund (hereafter referred to as “CHEF”) is authorized by section 202 of the Indian Health Care Improvement Act (IHCIA) [25 U.S.C. 1621a]. CHEF is administered by the Secretary, Department of Health and Human Services (HHS) (“the Secretary”) acting through the Headquarters of the Indian Health Service (IHS) (“the Service”), solely for the purpose of meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

(b) These regulations:

(1) Establish definitions of terms governing CHEF, including definitions of disasters and catastrophic illnesses for which the cost of treatment provided under contract would qualify for payment from CHEF;

(2) Establish a threshold level for reimbursement for the cost of treatment;

(3) Establish procedures for reimbursement of the portion of the costs incurred by Service Units that exceeds such threshold costs, including procedures for when the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

(4) Establish procedures for reimbursements pending the outcome or payment by alternate resources.

#### § 136.503 Threshold cost.

A Service Unit shall not be eligible for reimbursement from CHEF until its cost of treating any victim of a catastrophic illness or disaster for an episode of care has reached a certain threshold cost.

(a) The threshold cost shall be established at the level of \$19,000.

(b) The threshold cost in subsequent years shall be calculated from the threshold cost of the previous year, increased by the percentage increase in the medical care expenditure category of

the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year. The revised threshold costs shall be published yearly in the **Federal Register**.

#### § 136.504 Reimbursement procedure.

Service Units whose scope of work and funding include the purchase of medical services from private or public vendors under PRC are eligible to participate. CHEF payments shall be based only on valid PRC expenditures, including expenditures for exigent medical circumstances without prior PRC authorization. Reimbursement from CHEF will not be made if applicable PRC requirements are not followed.

(a) *Claim Submission*. Requests for reimbursement from CHEF must be submitted to the appropriate IHS Area Office. Area PRC programs will review requests for reimbursement to ensure compliance with PRC requirements, including but not limited to: Patient eligibility, medical necessity, notification requirements for emergent and non-emergent care, medical priorities, allowable expenditures, and eligibility for alternate resources.

(b) *Content of Claims*. All claims submitted for reimbursement must include:

(1) A fully completed Catastrophic Health Emergency Fund Reimbursement Request Form.

(2) A statement of the provider's charges in paper form. The paper form must comply with the format required for the submission of claims under title XVIII of the Social Security Act. For example, charges may be printed on forms such as the Centers for Medicare & Medicaid Services (CMS) 1450, American Dental Association (ADA) dental claim form, CMS 1500, or National Council for Prescription Drug Program (NCPDP) universal claim forms. The forms submitted for review must include specific appropriate diagnostic and procedure codes.

(3) An explanation of benefits or statement of payment identifying how much was paid to the provider by the Service Unit for the Catastrophic Illness or Disaster. Payments to the patient or any other entity are ineligible for CHEF reimbursement.

(4) The Division of Contract Care may request additional medical documentation describing the medical treatment or service provided, including but not limited to discharge summaries and/or medical progress notes. Cases may be submitted for 50% reimbursement of eligible expenses pending discharge summaries. Medical

documentation must be received to close the CHEF case.

(c) *Limitation of Funds and Reimbursement Procedure.* Because of the limitations of funds, full reimbursement cannot be guaranteed on all requests and will be based on the availability of funds at the time IHS processes the claim. To the extent funds are available, CHEF funds may not be used to cover the cost of services or treatment for which the funds were not approved. Unused funds, including but not limited to, funds unused due to overestimates, alternate resources, and cancellations must be returned to CHEF.

**§ 136.505 Reimbursable services.**

The costs of catastrophic illnesses and disasters for distinct episodes of care are eligible for reimbursement from CHEF in accordance with the medical priorities of the Service. Only services that are related to a distinct episode of care will be eligible for reimbursement.

(a) Some of the services that may qualify for reimbursement from the fund are:

- (1) Emergency treatment.
  - (2) Emergent and acute inpatient hospitalization.
  - (3) Ambulance services; air and ground (including patient escort travel costs).
  - (4) Attending and consultant physician.
  - (5) Functionally required reconstructive surgery.
  - (6) Prostheses and other related items.
  - (7) Reasonable rehabilitative therapy exclusive of custodial care not to exceed 30 days after discharge.
  - (8) Skilled nursing care when the patient is discharged from the acute process to a skilled nursing facility.
- (b) Reserved.

**§ 136.506 Alternate resources.**

(a) Expenses paid by alternate resources are not eligible for payment by PRC or reimbursement by CHEF. No payment shall be made from CHEF to any Service Unit to the extent that the provider of services is eligible to receive payment for the treatment from any other Federal, State, Tribal, local, or private source of reimbursement for which the patient is eligible. A patient shall be considered eligible for such resources and no payment shall be made from CHEF if:

- (1) The patient is eligible for alternate resources, or
- (2) The patient would be eligible for alternate resources if he or she were to apply for them, or
- (3) The patient would be eligible for alternate resources under Federal, State, Tribal or local law or regulation but for the patient's eligibility for PRC, or other health services, from the Indian Health Service or Indian Health Service funded programs.

(b) The determination of whether a resource constitutes an alternate resource for the purpose of CHEF reimbursement shall be made by the Headquarters of the Indian Health Service, irrespective of whether the resource was determined to be an alternate resource at the time of PRC payment.

**§ 136.507 Program integrity.**

(a) All CHEF records and documents will be subject to review by the respective Area and by Headquarters.

(b) Internal audits and administrative reviews may be conducted as necessary to ensure compliance with PRC regulations and CHEF policies.

**§ 136.508 Recovery of reimbursement funds.**

In the event a Service Unit has been reimbursed from CHEF for an episode of

care and that same episode of care becomes eligible for and is paid by any Federal, State, Tribal, local, or private source (including third party insurance) the Service Unit shall return all CHEF funds received for that episode of care to the CHEF at IHS Headquarters. These recovered CHEF funds will be used to reimburse other valid CHEF requests.

**§ 136.509 Reconsideration and appeals.**

(a) Any Service Unit to whom payment from CHEF is denied will be notified of the denial in writing together with a statement of the reason for the denial. In order to seek review of the denial decision, the Service Unit must follow the procedures set forth in paragraphs (b) and (c) of this section.

(b) Within 30 days from the receipt of the denial provided in paragraph (a) the Service Unit may submit a request in writing for reconsideration of the original denial to the Division of Contract Care. The request for reconsideration must include, as applicable, corrections to the original claim submission necessary to overcome the denial; or a statement and supporting documentation establishing that the original denial was in error. If no additional information is submitted the original denial will stand.

(c) If the original decision is affirmed on reconsideration, the Service Unit will be notified in writing and advised that an appeal may be taken to the Director, Indian Health Service, within 30 days of receipt of the denial. The appeal shall be in writing and shall set forth the grounds supporting the appeal. The decision of the Director, Indian Health Service, shall constitute the final administrative action.

[FR Doc. 2016-01138 Filed 1-25-16; 8:45 am]

**BILLING CODE 4165-16-P**