mortgages, respectively. A mortgagee or lender approved under this paragraph is not required to meet a net worth requirement. A lender or mortgagee shall maintain fidelity bond coverage and errors and omissions insurance acceptable to the Secretary and in an amount required by the Secretary, or alternative insurance coverage approved by the Secretary, that assures the faithful performance of the responsibilities of the mortgagee. There are no additional requirements beyond the general approval requirements in § 202.5 or as provided under paragraph (c) of this section.

(b) *Government-Sponsored Enterprises.* The Government-Sponsored Enterprises are the Federal Home Loan Banks, Federal Home Loan Mortgage Corporation, and Federal National Mortgage Association. A Government-Sponsored Enterprise may be an approved lender or mortgagee. A lender or mortgagee approved under this paragraph may purchase, service, or sell Title I loans and insured mortgages, respectively. A mortgagee or lender approved under this paragraph is not required to meet a net worth requirement. There are no additional requirements beyond the general approval requirements in § 202.5.

* * * * *

(d) *Audit requirements.* The insuring of loans and mortgages under the Act constitutes ''Federal financial assistance'' (as defined in 2 CFR 200.1) for purposes of audit requirements set out in 2 CFR part 200, subpart F. Non-Federal entities (as defined in 2 CFR 200.1) that receive insurance as lenders and mortgagees shall conduct audits in accordance with 2 CFR part 200, subpart F.

Julia R. Gordon,

Assistant Secretary for Housing—Federal Housing Commissioner.

[FR Doc. 2023–15033 Filed 7–17–23; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

42 CFR Part 136

RIN 0917–AA10

Catastrophic Health Emergency Fund

AGENCY: Indian Health Service, HHS.

ACTION: Proposed rule.

SUMMARY: The Indian Health Service (IHS or Service) administers the Catastrophic Health Emergency Fund (CHEF) pursuant to section 202 of the Indian Health Care Improvement Act (IHCIA). The purpose of the 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 notice proposes regulations governing the administration of the CHEF.

DATES: Send comments on or before September 18, 2023.

ADDRESSES: You may submit comments by the following method:

Electronically: Go to the Federal eRulemaking Portal: *https://www.regulations.gov.* In the Search box, enter the Regulation Identifier Number (RIN) (presented above in the document headings). For best results, do not copy and paste the number; instead, type the RIN into the Search box using hyphens. Then, click on the Search button. On the resulting page, in the panel on the left side of the screen, under the Document Type heading, check the Proposed Rule box to locate this document. You may submit a comment by clicking on ''Comment.''

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by the IHS. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All submissions are voluntary, and such voluntary submission of personal identifying information (*e.g.,* name, address, etc.), confidential business information, or otherwise sensitive information constitutes permission for IHS to make the information publicly accessible. The IHS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous).

FOR FURTHER INFORMATION CONTACT: For technical questions concerning this rule contact: Carl Mitchell, Director, Division of Regulatory and Policy Coordination (DRPC), Office of Management Services (OMS), Indian Health Service, 301–443–6384, *carl.mitchell@ihs.gov;* or CAPT John Rael, Director, Office of Resource Access and Partnerships (ORAP), Indian Health Service, 301–443–0969, *john.rael@ihs.gov.*

SUPPLEMENTARY INFORMATION: The CHEF was established by section 202 of the IHCIA, Public Law 94–437 (25 U.S.C. 1621a). The Patient Protection and Affordable Care Act, Public Law 111–148 as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (collectively, the Affordable Care Act or ''the ACA''), reauthorized the IHCIA and amended the CHEF, directing the Secretary to promulgate regulations governing the administration of the CHEF.

I. Background

The purpose of the 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. The IHS administers the CHEF to reimburse certain IHS and Tribal purchased/referred care (PRC) costs that exceed the cost threshold. Although the 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. The IHS developed operating guidelines for the management of the CHEF in August of 1987, which were approved by the Office of Management and Budget (OMB). Those guidelines were developed with input from Tribal Organizations and the 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 IHCIA, Public Law 94–437. Section 202 of the IHCIA (25 U.S.C. 1621a) establishes the 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 the proposed rule published January 26, 2016, (81 FR 4239). Following additional consultation and additional years of experience, the IHS is issuing this new notice of proposed rulemaking (NPRM). This NPRM supersedes and replaces the proposed rule published January 26, 2016, (81 FR 4239); as such, the 2016 NPRM is hereby rescinded.

II. Provisions of This Proposed Regulation

This regulation proposes to (1) establish definitions governing the 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 the 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 the 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 the 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 the 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. 5301 *et seq.*) and may not be allocated, apportioned, or delegated to a Service Unit, Area Office, or any other IHS organizational unit. Accordingly, the IHS Division of Contract Care within ORAP, IHS, shall remain responsible for administration of the CHEF.

The proposed regulation also incorporates provisions on severability. Congress has specifically directed the promulgation of these rules for the administration of the CHEF, which 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''). The sole purpose of the CHEF is meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service. In the event that any portion of the proposed regulation is declared invalid, the Secretary, acting through the IHS, will continue to be responsible for the administration of the CHEF. The IHS anticipates that the remainder of the regulation could function sensibly and continue to govern the administration of the CHEF. For these reasons, if any portion of the proposed regulation is declared invalid, the IHS intends that the remaining provisions be severable.

A. Definitions

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

1. Alternate Resources—health care resources other than those of the IHS. 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, Medicaid), state or local health care programs, and private insurance.

2. Catastrophic Health Emergency Fund (CHEF)—the fund established by Congress to reimburse extraordinary medical expenses incurred for catastrophic illnesses and disasters paid by a PRC program of the IHS, whether such program is carried out by the IHS or an Indian Tribe or Tribal Organization under the ISDEAA.

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 certain mental disorders. The CHEF is intended to insulate the IHS and Tribal PRC operations from financial disruption caused by the intensity of expenses incurred as a result of high cost illnesses and/or disasters.

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. The CHEF is intended to insulate the IHS and Tribal PRC operations from financial disruption caused by the intensity of expenses incurred as a result of high cost illnesses and/or disasters.

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 that 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 annual designated amount above which incurred medical costs will be considered for the CHEF reimbursement after a review of the authorized expenses and diagnosis.

B. Threshold Cost

The IHCIA section 202 provides that a Service Unit shall not be eligible for reimbursement from the 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.

The IHS intends to set the initial threshold governed by this rule at $19,000 for FY 2023. In reaching this determination, the IHS adopted the recommendation of the IHS Director's Workgroup on Improving PRC (Workgroup). 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 the CHEF earlier in the fiscal year 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–U Medical 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, the IHS intends to set the initial threshold at $19,000 for FY 2023, with increases in subsequent years based on the annual CPI–U Medical factor. The IHS will publish the revised threshold costs yearly in the **Federal Register**.

C. Compliance With PRC Regulations

The IHS proposes to follow PRC regulations 42 Code of Federal Regulations (CFR) part 136 for payment from the CHEF. For example, payment or reimbursement from the 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 the CHEF requests for CHEF reimbursement to ensure consistency with PRC regulations. The IHS seeks comment on whether payments by PRC programs to patients, or other individuals/entities that are not PRC providers, should be included as eligible for CHEF reimbursement under these regulations and if so, under what circumstances.

D. Alternate Resources

In accordance with section 202(d)(5) of the IHCIA [25 U.S.C. 1621a (d)(5)], alternate resources must be exhausted before reimbursement is made from the CHEF. No reimbursement shall be made from the CHEF to any Service Unit to the extent that the provider of treatment 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. 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 the IHS. The 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 the CHEF to the extent the IHS would not consider the other resources to be ''alternate resources'' under the applicable regulations and the IHS policy. Expenses paid by alternate resources are not eligible for payment by PRC or reimbursement by the CHEF. However, if the patient is found to have been eligible for alternate resources at the time of service, the Service Unit shall promptly return all funds reimbursed from the 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 the 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 the CHEF. Reimbursable costs are those costs that exceed the threshold requirement after payment has been made by all alternate resources such as Federal, state, 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 the CHEF shall be subject to availability of funds.

F. Recovery of the CHEF Reimbursement Funds

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

III. Collection of Information Requirements

Prior to implementing the rule, the 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 normally received 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 the preamble of this proposed rule, 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); and E.O. 13175 Consultation and Coordination with Indian Tribal Governments.

A. Executive Order 12866

Executive Order 12866, as amended by Executive Order 14094, 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). Section 3(f) of Executive Order 12866, as amended, defines a ''significant regulatory action'' as one that is likely to result in a rule that may: (1) have an annual effect on the economy of $200 million or more in any one year (adjusted every three years by the Administrator of OIRA for changes in gross domestic product), or adversely affect in a material way a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities (2) create a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in Executive Order 12866. While the Office of Information and Regulatory Affairs has determined that this is a significant regulatory action as defined by Executive Order 12866, they have also determined that it does not confer significant costs and does not warrant a regulatory impact analysis.

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, because the rule only governs reimbursements of certain expenditures made by Service Units under Purchased/Referred Care (PRC) authorities. Many PRC programs are operated by the Federal Government, through the Indian Health Service (IHS). The remaining PRC programs are operated by Tribes and tribal organizations under Indian Self-Determination and Education Assistance Act (ISDEAA) agreements with the IHS. Presently, there are 62 federally operated PRC programs and 188 tribally operated PRC programs. Some of the entities operating PRC programs may be small entities, but the rule does not directly impact a substantial number of small entities and the rule is not expected to reduce their revenues or raise their costs.

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 or more (adjusted annually for inflation) in any one year. The current threshold after adjustment for inflation is $165 million, using the most current (2021) Implicit Price Deflator for the Gross Domestic Product. 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 the UMRA threshold in any one year. The IHS FY 2022 annual appropriation for the CHEF was $53 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 $165 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. 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.

The first proposed CHEF rule, published in January 2016 (81 FR 4239), was developed with input from Tribes and the IHS personnel who work with the daily processing and management of PRC resources. Specifically, the IHS Director's Workgroup on Improving PRC met and discussed the CHEF guidelines on October 12–13, 2010, and June 1–2, 2011, in Denver, Colorado, and on January 11–12, 2012, in Albuquerque, New Mexico. In addition, the IHS issued ''Dear Tribal Leader'' letters related to the development of these regulations on February 9, 2011, and May 6, 2013.

The IHS has sought additional Tribal input throughout the development of this new proposed rule. Specifically, Tribal consultation sessions were held in the fall of 2016. At meetings of the Workgroup in 2015 and 2018, the Workgroup recommended establishing a $19,000 CHEF threshold. Moreover, in November 2020, the Workgroup recommended that the IHS promulgate new regulations based on Workgroup input. 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 additional Tribal consultation with affected Tribes by giving interested Tribes the opportunity to comment on the regulation before it is finalized. The 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, Purchased/Referred Care (formerly Contract Health Services), Health, Health facilities, Indians.

For the reasons set out in the preamble, the IHS 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 §§ 136.501–136.510 to read as follows:

Subpart L—Indian Catastrophic Health Emergency Fund

Sec.

§ 136.501 Definitions.

Alternate Resources means health care resources other than those of the Indian Health Service. 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, Medicaid), state or local health care programs, and private insurance.

Catastrophic Health Emergency Fund (CHEF) means the fund established by Congress to reimburse extraordinary medical expenses incurred for catastrophic illnesses and disasters paid by a PRC program of the IHS, whether such program is carried out by the IHS or an Indian Tribe or Tribal Organization under the ISDEAA.

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. The CHEF is intended to insulate the IHS and Tribal PRC operations from financial disruption caused by the intensity of expenses incurred as a result of high cost illnesses and/or disasters.

Disaster means a situation that 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. The CHEF is intended to insulate the IHS and Tribal PRC operations from financial disruption caused by the intensity of expenses incurred as a result of high cost illnesses and/or disasters.

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

§ 136.502 Purpose of the regulations.

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]. The 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.

These regulations:

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

(b) establish a threshold level for reimbursement for the cost of treatment;

(c) 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

(d) 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 the 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. The CHEF payments shall be based only on valid PRC expenditures, including expenditures for exigent medical circumstances without prior PRC authorization. Reimbursement from the CHEF will not be made if applicable PRC requirements are not followed.

(a) *Claim Submission:* Requests for reimbursement from the 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. Following this review, Area PRC programs may provide Service Units an opportunity to submit missing information or to resubmit documents that are indecipherable. Area PRC programs will then forward all requests to the Division of Contract Care, along with any recommendations or observations from the Area PRC program regarding compliance with PRC or other CHEF requirements. The Division of Contract Care will adjudicate the claim based upon an independent review of the claim documentation, but it may consider any recommendations or observations from the Area PRC program.

(b) *Content of Claims:* All claims submitted for reimbursement may be submitted electronically utilizing the secure IHS system(s) established for this purpose or may be submitted in paper form but must include:

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

(2) A statement of the provider's charges on a form that complies 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) 1500, UB–04 (formerly CMS–1450), American Dental Association (ADA) dental claim form, 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 the 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 the IHS processes the claim. To the extent funds are available, the 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 the CHEF.

§ 136.505 Reimbursable services.

The costs of catastrophic illnesses and disasters for distinct episodes of care are eligible for reimbursement from the 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 the CHEF. No payment shall be made from the 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, 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 the 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, 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 the 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.

All the CHEF records and documents will be subject to review by the respective Area and by Headquarters. Internal audits and administrative reviews may be conducted as necessary to ensure compliance with PRC regulations and the CHEF policies.

§ 136.508 Recovery of reimbursement funds.

In the event a Service Unit has been reimbursed from the CHEF for an episode of care and that same episode of care becomes eligible for and is paid by any Federal, state, local, or private source (including third party insurance) the Service Unit shall return all the CHEF funds received for that episode of care to the CHEF at the 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 the CHEF is denied will be notified of the denial in writing together with a statement of the reason for the denial within 130 business days from receipt.

(b) If a decision on the CHEF case is not made by the CHEF Program Manager within 180 calendar days from receipt, the Service Unit that submitted the claim may choose to appeal it as a deemed denial.

(c) In order to seek review of a denial decision or deemed denial, the Service Unit must follow the procedures set forth in paragraphs (c)(1) and (c)(2) of this section.

(1) Within 40 business days from the receipt of the denial provided in paragraph (a) of this section, 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. The Service Unit may also request a telephone conference with the Division of Contract Care, to further explain the materials submitted, which shall be scheduled within 40 business days from receipt of the request for review. A decision by the Division of Contract Care shall be made within 130 business days of the request for review. The Division of Contract Care Director, or designee, shall review the application *de novo* with no deference to the original decision maker or to the applicant.

(2) 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 40 business days of receipt of the denial. The appeal shall be in writing and shall set forth the grounds supporting the appeal. The Service Unit may also request a telephone conference through the Division of Contract Care, which shall be scheduled with the Director or a representative designated by the Director, to further explain the grounds supporting the appeal. A decision by the Director shall be made within 180 calendar days of the request for reconsideration. The decision of the Director, Indian Health Service or designee, shall constitute the final administrative action.

§ 136.510 Severability.

If any provision of this subpart is held to be invalid or unenforceable by its terms, as applied to any person or circumstance, or stayed pending further agency action, the provision shall be construed to continue to give the maximum effect to the provision permitted by law, including as applied to those not similarly situated or to dissimilar circumstances. However, if such holding is that the provision of this subpart is invalid and unenforceable in all circumstances, the provision shall be severable from the remainder of this subpart and shall not affect the remainder thereof.

Dated: July 10, 2023.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2023–14849 Filed 7–17–23; 8:45 am]

BILLING CODE 4165–16–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Chapter IV

[CMS–5540–NC]

RIN 0938–AV19

Request for Information; Episode-Based Payment Model

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health of Human Services (HHS).

ACTION: Request for information.

SUMMARY: This request for information seeks input from the public regarding the design of a future episode-based payment model. Responses to this request for information may be used to inform potential future rulemaking or other policy development.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by August 17, 2023.

ADDRESSES: In commenting, refer to file code CMS–5540–NC.

Comments, including mass comment submissions, must be submitted in *one* of the following three ways (please choose only *one* of the ways listed):

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–5540–NC, P.O. Box 8013, Baltimore, MD 21244–8013.

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 following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–5540–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.