CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

June 16, 2006

Betty Gould, Regulations Officer
Division of Regulatory Affairs, Records
Access and Policy Liaison
Indian Health Service
801 Thompson Avenue
Suite 450
Rockville. Maryland 20852

Subject: Comments on Section 506, MMA 2003-Medicare Like Rates Provisions

Ms. Gould:

The California Rural Indian Health Board Inc. is a Tribal Organization operating under the authorities of the Indian Self Determination Act under resolutions from 23 Tribal Governments in the state of California to provide health and related services on their behalf. Because there are no IHS funded Hospital Facilities in California all inpatient care provided with IHS and Tribal funds are provided by local community hospitals on either a contracted rate or fee for service basis. The proposed rules will have a positive economic impact on IHS funded Tribally operated health programs in California by limiting the cost of those services. Because the IHS CHS eligible population in California is both small and widely dispersed it is impossible to command sufficient market shares to impact the cost of those services and other diagnostic and treatments provided in our local hospitals. We therefore support the implementation of the proposed rule as a rational and equitable means of controlling health costs. We are concerned that the requirements outlined in 136.30(e) (1) will have the adverse effect of increasing costs for Tribal Health Programs in California or prevent us from utilizing this new cost containment tool. As written it would require us to contract with a third party administrator or fiscal intermediary to pay our CHS claims, or purchase the software that would provide us with the comparative pricing necessary to validate the claim.

We therefore suggest the following language:

e) *Claims Processing*. For a hospital to be eligible for payment under this section, the hospital or its agent must submit the claim for authorized services —

(1)On UB92 paper claim form (until abolished, or on an officially adopted successor form) ~~**or the HIPAA 837 electronic claims format ANSI X12N, version 4010A1 (until abolished, or on an officially successor form)**~~ ***or other method agreed upon by the I/T/U*** **and include the hospital's Medicare provider number/National Provider Identifier**; and...

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Your consideration of this change would be most appreciated. Tribal Health Programs in California are grossly underfunded with an average funding level per IHS Active User of less than one half of that necessary to provide the benchmark Blue Cross plan coverage provided to federal employees under the Federal Employees Benefit Package. This lack of funding for core primary care services is compounded by the fact that California has never, and in all likely hood never will, receive IHS funding for Hospital Construction. This makes us truly dependent on CHS funds and services provided by local non IHS facilities to provide common inpatient care and many diagnostic services. The American Indian/Alaska Native population in California is widely dispersed. The California Contract Health Care Service Delivery Area (CHSDA) is four times larger than the Navajo Reservation. Yet in comparison the Navajo CHSDA is densely populated with eight people per square mile while the California CHSDA holds only one half Indian person per square mile.

For these and other reasons we urge the quick formalization of the proposed rule to implement section 506 of the Medicare Modernization Act of 2003.

Sincerely

James Allen Crouch M.P.H.
Executive Director

cc: CRIHB Board of Directors