MISSISSIPPI BAND OF CHOCTAW INDIANS

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June 27, 2006

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

RE: *Comments of the Mississippi Band of Choctaw Indians on proposed rule:* Sec. 506 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 -- Limitation on Charges for Services Furnished by Medicare Participating Inpatient Hospitals to Indians; 71 FED. REG. 25124 (April 28, 2006)

Dear Ms. Gould:

The Mississippi Band of Choctaw Indians operates the Choctaw Health Center and several community clinics on its reservation in Mississippi through a compact with the Indian Health Service issued pursuant to the Indian Self-Determination and Education Assistance Act. A key component of the Choctaw compact is operation of the Contract Health Services (CHS) program through which the Tribe purchases health services from public and private providers. Therefore, the Tribe is keenly interested in the above-referenced proposed regulations that (1) require Medicare-participating hospitals (including critical access hospitals) and all hospital departments and provider-based entities to participate in CHS programs operated by the IHS, Indian tribes, tribal organizations and urban Indian organizations; and (2) establish maximum rates which such hospitals, departments and entities may be paid for CHS services.

The Tribe strongly supports the proposed regulations and urges their implementation as soon as possible, as the limits they impose on the amounts Medicare-participating hospitals can be paid by CHS programs will enable the Indian health system to purchase more critically-needed health care for Indian beneficiaries. Chronic CHS funding shortages make it impossible for us to purchase all the care our patients require and force us to impose severe limitations on the medical conditions that qualify for CHS. With the health status of Indians lagging far behind that of other Americans, the Federal government has the obligation to enhance our ability to provide the level of care Indian patients need and deserve. It is well past the time to extend to the Indian health system a maximum rate structure long enjoyed by the Department of Defense health care system.

We do not understand why it has taken so long for the Department to issue these proposed regulations. Congress enacted Sec. 506 of the Medicare Prescription Drug, Improvement and Modernization Act in December, 2003, with a directive that it be implemented no later than December, 2004. The untoward delay in proposing regulations -- and the additional delay that will occur before they are finally implemented -- has denied the Indian health system the ability to obtain many millions of dollars of desperately needed health services.

While we support promulgation of the proposed regulations, the Department's obligation to achieve the full objective of Sec. 506 does not end there. Two other efforts are also needed:

1. *Rate verification mechanism*. The Secretary must establish an efficient and accessible mechanism for tribally-operated health programs to assure that the amounts charged by CHS hospitals do not exceed the maximum rates calculated through the methodology mandated by the regulations. While we understand that the IHS has a Fiscal Intermediary to check the amounts billed by its CHS hospital providers and make adjustments when they exceed the allowable maximums, many smaller tribal health programs, including ours, do not engage a Fiscal Intermediary to process our CHS bills.

Thus, the Indian Health Service must make available to these tribal programs appropriate electronic software that enables us to efficiently compare billed charges to the maximum allowable amounts and to make the same types of adjustments the IHS's FI would make when errors are found. While the regulations allow for adjustments to "correct billing or claims processing errors" (42 CFR 136.30(b)), this is not a sufficient solution to the very real potential for errors -- whether they result from mistake or fraud. Obviously, errors must be detected before they can be corrected. Efficiency dictates that we must have the ability to detect errors *before* payment, as post-payment error detection multiplies the staff resources needed to correct them and reduces the opportunity for correction. Since the CHS payment rates will not be identical to the Medicare interim rates, billing errors *will* occur, and their occurrence is likely to be even higher in the initial implementation period as CHS hospital providers develop internal business office procedures for compliance.

Therefore, we ask the Secretary to immediately direct IHS to provide tribally-operated programs with access to electronic software needed to fully implement Sec. 506 and the regulations.

2. *No offsets from future CHS budget requests*. It is beyond dispute that Congress's intent in enacting Sec. 506 was to enable Indian health programs to purchase *more* CHS services for their patients. This objective can only be achieved if the budget amounts for CHS are maintained and increased in an amount that at least keeps up with medical inflation. Thus, we urge the Secretary to assure that no effort is made to offset from future budget requests any "savings" that may be perceived to flow from the cap on CHS hospital payments. Any such action would be an unconscionable breach of the United States' trust responsibility for Indian health and would directly contravene the intent of Congress expressed in Sec. 506.

Conclusion. The Mississippi Band of Choctaw Indians endorses these regulations with the recommendations stated above and urges their immediate promulgation.

Sincerely yours,

Phillip Martin
Tribal Chief