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Betty Gould
Regulations Officer
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Indian Health Service
801 Thompson Ave., Suite 450
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June 22, 2006

Re: Proposed Rules, 42 C.F.R. Parts 136 and 489

Dear Ms. Gould:

This law firm serves as general legal counsel for the Tuba City Regional Health Care Corporation ("TCRHCC"), a corporation organized under the law of the Navajo Nation that operates the Tuba City Regional Health Care Center within the Navajo Nation in Arizona pursuant to an Indian Self-Determination Education and Assistance Act ("Pub. L. 93-638" or "638") contract. As a 638 contractor, TCRHCC receives contract health service (CHS) funds from the Indian Health Service and carries out a CHS program pursuant to its 638 contract. This letter constitutes the comments of TCRHCC in response to the notice published at 71 *Federal Register* 25124 on April 28, 2006, for the adoption of a proposed rule establishing regulations, 42 C.F.R. Parts 136 and 489, required by section 506 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003,* Pub. L. 108-173, 117 Stat. 2066 (2003).

1. Proposed Subpart D—Limitation on Charges for Services Furnished by Medicare-participating Hospitals to Indians

42 C.F.R. § 136.30. TCHRCC agrees with the proposed Subpart D regulations, 42 C.F.R. section 136.30, which provide the detailed rules for the implementation of rate limitations approved by Congress in 42 U.S.C. § 1395cc(a)(1)(U). TCRHCC provides medical services for Indian patients, refers them to non-tribal Medicare-participating hospitals located outside the Navajo Reservation and pays the hospitals for these services through its fiscal

intermediary. Until recently, these off-Reservation hospitals have accepted Medicare rates as reimbursement for these contract health referrals. Lately, however, some of these Medicare-participating hospitals have stated that they will no longer accept reimbursement at Medicare rates and will, if not paid for full hospital charges, refuse to accept contract health patients referred from TCRHCC. Because of the history of chronic under-funding of healthcare services for Indians, this demand for reimbursement at rates significantly higher than Medicare rates only further reduces the already limited funds available for the treatment of Indian patients within the Reservation. Therefore, it is critical to TCRHCC that it is not charged rates higher than Medicare will reimburse for contract health services.

42 C.F.R. § 136.30(c). TCRHCC also agrees that, in the event a 638 hospital can negotiate rates for outside services that are lower than Medicare rates, that this arrangement should be permissible. This provision will encourage cooperative efforts among different types of Indian health care providers, and provide benefits for those 638 hospitals able to negotiate favorable rates.

42 C.F.R. § 136.30(d). TCRHCC also agrees that it and other 638 hospitals should be the payors of last resort and coordinate payments for outside services with other benefits available to the patient. This is consistent with existing regulations, 42 C.F.R. section 136.61, and TCRHCC abides by these terms. In addition, this rule allows 638 hospitals to conserve its limited funding and provide services that it would be unable to provide if they were payors of first resort.

42 C.F.R. § 136.30(e). TCRHCC agrees that outside hospitals must be required to comply with established Medicare claim processing procedures to be eligible for payment by TCRHCC. This ensures that TCRHCC will not be required to consider or honor requests for payment made in an unorthodox or disputable manner, or at rates higher than Medicare rates.

42 C.F.R. § 136.30(g). This provision states that once a payment is made pursuant to the methodology established by Section 136.30, a hospital that receives the patient who is referred by a CHS program must accept that as payment in full. It is TCRHCC's recent experience that this section is critical, as off-Reservation hospitals have taken the position that they are not limited to Medicare rates for reimbursement, but may collect full hospital charges for such referrals. This section makes clear that such a practice is prohibited.

2. Subpart B—Essentials of Provider Agreements

42 C.F.R. § 489.29. As noted above, it has been the recent experience of TCRHCC that off-Reservation, Medicare-participating hospitals that have historically received TCRHCC's CHS patients are now taking the position that they will not accept Medicare rates for services provided to these patients and that they have a right to refuse these referrals unless TCRHCC agrees to pay full hospital rates for these services. Section 489.29 will end this practice by clarifying that acceptance of CHS patients at Medicare rates is a condition of participation in

Medicare, as required by Congress in 42 U.S.C. § 1395cc(a)(1). The proposed new regulation effectively ensures that outside hospitals providing services to Indians authorized by TCRHCC and other Pub. L. 93-638 health care facilities will accept the Medicare-like payments for services as provided in new section 136.30 or risk losing their ability to participate in Medicare. This provides adequate and needed support to the Part 136 regulations.

3. Application of Medicare Rate Limits in the Absence of Regulations

TCRHCC is concerned that the hospitals to which it refers CHS patients are operating under the mistaken belief that they have no obligation to follow the rate limits for CHS referrals adopted by Congress in 42 U.S.C. § 1395cc(a)(1)(U) *until* the proposed regulations have been approved by the Secretary. TCRHCC has been advised by these Medicare-participating hospitals that, because Subpart U of Section 1395cc(a)(1) is to be implemented "in accordance with regulations promulgated by the Secretary" that the rate limitation directed by Congress to conserve the limited resources of Indian CHS programs is presently inapplicable. TCRHCC believes that this position is inconsistent with the intent of Congress in approving Subpart U.

The Senate added subpart U to the legislation that became Public Law 108-173 late in the legislative process. The Conference Report stated the intention of the Senate Bill:

> The amendment would *prohibit* hospitals that participate in Medicare and that provide Medicare covered inpatient hospital services under the contract health services program funded by the Indian Health Services *from charging more than the Medicare established rates for these services*. This provision would apply to contract health services programs operated by the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization. The provision would apply to Medicare participation agreements in effect or entered into by a date specified by the Secretary. *In no case would this provision be applicable later than 6 months from the date of enactment.*

H.R. CONF. REP. NO. 108-391, at H12049 (2003)(emphasis supplied). It is evident that, at this stage in the legislative process, Congress was concerned that the regulations might not be adopted in a timely manner and, therefore, felt compelled to make clear that the rate limitations would come into effect on a date certain, regardless of whether the Secretary had actually adopted regulations. Although Congress finally approved a somewhat longer time period than the six months proposed by the Conference Report, the basic concept that the rate limitations would go into effect on a date certain, regardless of the status of the regulations was included in the final legislation. Section 506 of P.L. 108-173, entitled "Limitation on Charges for Inpatient Hospital Contract Health Services Provided to Indians by Medicare Participating Hospitals," includes the following statement:

> The amendments made by this section [42 U.S.C. § 1395cc] shall apply as of a date specified by the Secretary of Health and Human Services (***but in no***

> ***case later than 1 year after the date of enactment of this Act***) to medicare [sic] participation agreements in effect (or entered into) on or after such date. (Emphasis supplied)

P.L. 108-173 was enacted on December 8, 2003, and the rate limitation for CHS reimbursements therefore went into effect on December 8, 2004, regardless of whether the Secretary had adopted regulations. Consequently, the participation agreements of Medicare-participating hospitals have been subject to the rate limitation imposed by Subpart U and have prohibited those hospitals from charging greater than Medicare rates for CHS patient referrals since late 2004. Any present effort by a Medicare-participating hospital to collect full hospital charges on CHS referrals from a 638 contractor would violate Subpart U and make the hospital subject to termination of its Medicare participation agreement, even without the Secretary's approval of the proposed regulations.

4. Conclusion

TCRHCC urges the Indian Health Service and Centers for Medicare & Medicaid Services to enact the proposed regulations as written. The proposed regulations provide appropriate support and security to Pub. L. 93-638 hospitals that authorize services for their patients at outside facilities. Capping the payments for outside services at the rates chargeable to Medicare, while allowing facilities to negotiate for more favorable rates, provides consistency and stability in the system. The proposed regulations are consistent with existing law and the federal government's trust relationship with Indian tribes, and that the regulations are clear and enforceable. Perhaps most importantly, approval of the regulations will eliminate the specious arguments of Medicare-participating hospitals that they can collect full charges from 638 contractors and will clarify that charging more than Medicare rates will imperil their continued participation in Medicare, as Congress intended. Thank you for your consideration of the comments of TCRHCC.

Sincerely,

MAYNES, BRADFORD, SHIPPS & SHEFTEL, LLP

Kade Buk

FOR

Steven C. Boos

xc: Joe Engelken, CEO
Tuba City Regional Health Care Corporation

Pete Hoskie, Chairman of the Board
Tuba City Regional Health Care Corporation