Choctaw Nation of Oklahoma

Self-Governance

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February 2, 2015

Betty Gould, Regulations Officer
Indian Health Service
801 Thompson Avenue
TMP STE 450
Rockville, MD 20852

RE: **Comments on Proposed Medicare-Like Rates Application to Purchase Referred Care (42 CFR Part 136).**

Dear Ms. Gould:

The Choctaw Nation of Oklahoma would like to revise our comments pertaining to the above-referenced proposed rule. At first reading, the proposed rule appeared to be something we could whole-heartedly support, but further study has raised some very serious issues:

- The Proposed Rule is an infringement on Tribal Sovereignty. Tribes and Tribal programs operating under P.L. 93-638 as amended cannot be forced to accept the new rule and operate under its precepts as is stated in the proposal.
- The proposed rule is unenforceable. The Centers for Medicare and Medicaid Services (CMS) has indicated that it has no intention to enforce this ruling on providers, and providers have no incentive to accept its terms.
- Finding providers/specialists who will agree to the Medicare-Like Rates (MLR) rule may actually harm the quality of, and access to care for our patients. How far 'down the line' will Tribes have to go—from Best to Worst—to find doctors and facilities who will agree to the proposed rule? Further, in rural areas alternate providers may simply be unavailable, thus harming access to care.
- How much farther will patients have to travel to be able to see that needed specialist? The proposed rule could cause our patients to have to travel great distances to receive needed care. The cost of this travel—hotels, etc.—could easily consume any savings obtained by getting the lower MLR.
- There would need to be 'exceptions' written into this proposed rule.
- The proposed rule would have to include an "opt-out" clause. In Oklahoma for instance, Tribes tend to have long-standing contracts with providers and specialists that are agreeable to both

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parties. Attempting to force these providers into an 'all-or-nothing' agreement can easily backfire and harm access to care by losing these contractors.

- The title of the proposed rule is misleading as to what the proposed rule actually is.

Given these major problems with the proposed rule to require providers to accept MLR, the Choctaw Nation supports the "Redline" proposal that has been developed nationally by Tribes facilitated by the National Indian Health Board, the Indian Health Service Tribal Self-Governance Advisory Committee and others. That redline version is attached. Key portions of this Tribal proposal are to include specific "Exceptions" allowing IHS/Tribes/Urban programs to negotiate alternate rates if they are beneficial to the I/T/U, as well as an important provision for Tribes operating under P.L. 93-638 to adopt the rule at their option (an "opt out" provision). The Choctaw Nation can only support the Proposed Rule if these changes are incorporated as attached herein.

If you have questions, please contact the Choctaw Nation's Executive Director of Self-Governance, Mickey Peercy, at mpeercy@choctawnation.com or by phone at (580) 924-8280, extension 2240.

Respectfully,

/Gary Batton, Chief/

Gary Batton, Chief

For the reasons set forth 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 continues to read as follows:

Authority: 25 U.S.C. 13; 42 U.S.C. 1395cc (a) (1) (U), 42 U.S.C. 2001 and 2003, unless otherwise noted.

2. Add new subpart I consisting of §§ 136.201 and 136.202, to read as follows:

Subpart I—Limitation on Charges For ~~Health Care Professional Services~~ and Non-Hospital-Based Care

Commented [EAM1]: The existing MLR regulation applies to all hospital based services, including, if employed directly by the hospital, professional services, notwithstanding the IHS FAQ. This rule should not imply that professional services are never covered by the existing MLR regulations.

Sec.

136.201 Payment for physician and other health care professional services purchased by Indian health programs and other medical charges associated with non-hospital-based care.

136.202 Authorization by urban Indian organizations.

§ 136.201 Payment for ~~physician and other health care professional~~ services purchased by Indian health programs and other medical charges associated with non-hospital-based care.

Commented [EAM2]: Same comment. Change suggested so as not to imply that physician services are never covered by the existing MLR regulations.

(a) Payment ~~to physicians and health care professionals and all other~~for non-hospital-based entities, including non-hospital based physicians and professional services for any level of care authorized under part 136, subpart C by a Purchased/Referred Care (PRC) program of the Indian Health Service (IHS); or authorized by a Tribe or Tribal organization carrying out a PRC program of the IHS under the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93-638, 25 U.S.C. 450 et seq.; or authorized for purchase under § 136.31 by an urban Indian organization (as that term is defined in 25 U.S.C. 1603(h)) (hereafter "I/T/U"), shall be determined based on the applicable method in this section:

Commented [EAM3]: Same comment.

The I/T/U will pay the lowest of the following amounts:

(1) The applicable Medicare payment amount, including payment according to a fee schedule, a prospective payment system or based on reasonable cost ("Medicare

rate") for the period in which the service was provided, or in the event of a Medicare waiver, the payment amount will be calculated in accordance with such waiver.

(2)An amount that has been negotiated with a specific provider or its agent, or supplier or its agent by the I/T/U or the amount negotiated by a repricing agent if the provider or supplier is participating within the repricing agent's network and an I/T/U has a pricing arrangement or contract with that repricing agent. For the purposes of this section, repricing agent means an entity that seeks to connect I/T/U with discounted rates from non-I/T/U public and private providers as a result of existing contracts that the non-I/T/U public or private provider may have within the commercial health care industry.

(3) The amount that the provider or supplier ~~bills~~ accepts as payment for the same service from nongovernmental entities, including insurance providers~~the general public for the same service~~.

Commented [EAM4]: This change is suggested because the term "general public" is too vague. It is intended to cover reimbursements from non-governmental sources (i.e., not Medicaid, Medicare, VA, etc.). We suggest this change for accuracy and to avoid disputes as to what is meant by "general public."

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(b) Exception.

(1) Subpart (a) shall apply to a Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93-638, 25 U.S.C. 450 et seq., and urban Indian organizations (as that term is defined in 25 U.S.C. 1603(h) only at the election of the Tribe, Tribal organization or urban Indian organization.

~~(3)~~(2) The I/T/U, either directly or through a repricing agent, may elect to negotiate a rate that is more than the rate described in paragraph (a) of this section with a

Commented [EAM5]: Under the rule as drafted by the IHS, both IHS and tribes would only be able to pay no more than Medicare-Like Rates for any service. There is considerable concern that such an all-encompassing rule may create hardship for some PRC programs if certain providers refuse to see their patients at the Medicare-Like Rate. This exception would allow PRC programs to pay more than the MLR when necessary to ensure their patients have access to providers. However, it is capped at the lowest rate the provider accepts from others for the same service. This cap is designed to ensure that providers cannot simply insist on payment at full billed charges.

There is ongoing discussion as to whether this cap allows sufficient flexibility for Tribes that may already have, or may have to negotiate some other rate.

non-hospital based entity, but in no event shall such rate be higher than the lowest rate the non-hospital based entity certifies to the I/T/U that it accepts as payment for the same service from nongovernmental entities, including insurance providers.

(~~b~~c) Coordination of benefits and limitation on recovery: If an I/T/U has authorized payment for items and services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payer--

(1) The I/T/U is the payer of last resort under 25 U.S.C. 1623(b);

(2) If there are any third party payers, the I/T/U will pay the amount for which the patient is being held responsible after the provider or supplier of services has coordinated benefits and all other alternate resources have been considered and paid,

including applicable co-payments, deductibles, and coinsurance that are owed by the patient; and

(3) The maximum payment by the I/T/U will be only that portion of the payment amount determined under this section not covered by any other payer; and

(4) The I/T/U payment will not exceed the rate calculated in accordance with paragraph (a) or (b) of this section (plus applicable cost sharing); and

(5) When payment is made by Medicaid it is considered payment in full and there will be no additional payment made by the I/T/U to the amount paid by Medicaid.

~~(c)~~ (d) Authorized services: Payment shall be made only for those items and services authorized by an I/T/U consistent with part 136 of this title or section 503(a) of the Indian Health Care Improvement Act (IHCIA), Public Law 94-437, as amended, 25 U.S.C 1653(a).

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~~(d)~~ (e) No additional charges.

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(1) The health care provider or supplier shall be deemed to have accepted the applicable Medicare payment amount, including payment according to a fee schedule, a prospective payment system or based on reasonable cost ("Medicare rate") for the period in which the service was provided), or other payment amount in accordance with paragraph (b) of this Section, as payment in full if:

(i) The services were provided based on a PRC referral authorized for payment; or,

(ii) The health care provider or supplier submits a Notification of a Claim for payment to the I/T/U; or

(iii) The health care provider or supplier accepts payment for the provision of services from the I/T/U.

(2) A payment made and accepted in accordance with this section shall constitute payment in full and the provider or its agent, or supplier or its agent, may not impose any additional charge—

(i) On the individual for I/T/U authorized items and services; or

(ii) For information requested by the I/T/U or its agent or fiscal intermediary for the purposes of payment determinations or quality assurance.

(e) For ~~physicians and health care professionals and~~ all ~~other~~ non-hospital-based entities, including non-hospital based physicians and health care professionals required by law to accept the rates specified in this section, the applicable rate shall be the lowest of any amount calculated under paragraph (a)~~(1)~~ or (b) of this section, without regard to paragraph (d)(1) of this section.

(f) No service shall be authorized and no payment shall be issued in excess of the rate authorized by this ~~subpart~~Section.

§ 136.202 Authorization by an urban Indian organization.

An urban Indian organization may authorize for purchase items and services for an eligible urban Indian (as those terms are defined in 25 U.S.C. 1603(f) and (h)) according to section 503 of the IHCIA and applicable regulations. Services and items furnished by ~~physicians and other health care professionals and~~ non-hospital-based entities including non-hospital based physicians and other health care professionals shall be subject to the payment methodology set forth in § 136.~~30~~201.

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