

National Indian Health Board



Delivered via electronic transmission

June 6, 2011

Dr. Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1345-P
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Subject: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations (CMS-1345-P)

Dear Administrator Berwick:

Please find attached comments prepared by the National Indian Health Board¹ (NIHB) in response to the proposed rule issued by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services (HHS) regarding the Medicare Shared Savings Program: Accountable Care Organizations (CMS-1345-P; Proposed Rule) under section 3022 of the Patient Protection and Affordable Care Act (ACO) (Affordable Care Act or ACA).

NIHB is limiting its comments primarily, but not solely, to broad issues impacting the ability of Indian health system providers to form an ACO or to participate in an ACO, and to factors that may limit or impede the ability of Indian health system providers to continue to build a revenue base that is sufficient to adequately serve American Indians and Alaska Natives. Both sets of issues raise concerns over whether the Proposed Rule will further – or hinder – the efforts of the Indian health system to improve the coordination and quality of care provided to American Indians and Alaska Natives (AI/AN).

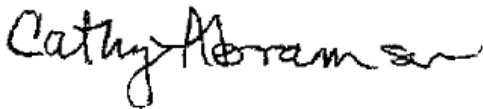
¹ Established nearly 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (“IHS”) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (“ISDEAA”), or continue to also rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate.



To ensure that Accountable Care Organizations and other payment and delivery system reforms initiated by CMS advance the health status of American Indians and Alaska Natives, NIHB recommends that CMS move to immediately engage tribal representatives in consultation. NIHB offers to assist CMS in this effort. Ultimately, in order to fully address the dynamics found in many AI/AN communities, the ACO model may be found not to be suitable, and there may be a need to pursue alternative approaches through the Medicare Innovations Center in order to achieve the objectives of greater coordination and better care for individuals, better health for populations, and lower growth in expenditures. Instituting a proactive consultation process between CMS and Indian Country would provide a vehicle for careful and thorough consideration of these issues.

Thank you for your consideration of these recommendations as we jointly work to advance the health status of American Indian and Alaska Native individuals and communities across the United States.

Sincerely,

A handwritten signature in black ink that reads "Cathy Abramson". The signature is written in a cursive, flowing style.

Cathy Abramson
Chairman, National Indian Health Board

Cc: Sally Smith, Chair, NIHB Medicare, Medicaid and Health Reform Policy
Committee (MMPC)
Dr. Yvette Roubideaux, Director, Indian Health Service
Stacy Bohlen, Executive Director, NIHB
Valerie Davidson, Chair, Tribal Technical Advisory Group to CMS
Jennifer Cooper, Legislative Director, NIHB
Kitty Marx, Director, CMS Tribal Affairs Group

Attachment: NIHB Analysis of Proposed Rule for Implementation of Section 3022 of the
Affordable Care Act: Accountable Care Organizations

National Indian Health Board



NIHB Analysis of Proposed Rule for Implementation of Section 3022 of the Affordable Care Act: Accountable Care Organizations

June 6, 2011

1. STATEMENT OF THE ISSUE.

The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) issued a proposed rule on the Medicare Shared Savings Program: Accountable Care Organizations (CMS-1345-P) (Proposed Rule) under section 3022 of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA).¹ ACA section 3022 creates a new Shared Savings Program under Medicare whereby “groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an Accountable Care Organization [ACO]...”² ACO’s are to be organized as separate legal entities. The authorizing law goes on to indicate that “ACO’s that meet quality performance standards established by the Secretary are eligible to receive payments for ‘shared savings’...”³

As indicated by CMS, the overall goal of the Medicare Accountable Care Organization initiative is to “better coordinate care for Medicare patients.”⁴ Medicare shared savings programs such as this ACO initiative, value-based purchasing, payment bundling, and other payment reforms aim to foster delivery system reforms. These initiatives are well underway, with the Affordable Care Act providing a tremendous boost to these efforts. Each of these efforts is aimed at providing: 1) better care for individuals; 2) better health for populations; and 3) lower growth in expenditures.⁵ The National Indian Health Board (NIHB) supports these objectives, and the programmatic initiatives in general, but NIHB is concerned about how these initiatives may or may not advance the coordination of care for American Indians and Alaska Natives given the baseline status of the Indian health system across the United States.

Without sufficient consultation between CMS officials and tribal representatives, and without adequate consideration of the day-to-day conditions affecting Indian health

¹ The Affordable Care Act, pursuant to Section 10221 of the ACA, includes amendments made to the Indian Health Care Improvement Act (Public Law 94-437), as the ACA incorporated by reference S. 1790 as reported by the Committee of Indian Affairs of the Senate.

² Section 1899(a)(1)(A) of the Social Security Act.

³ Section 1899(a)(1)(B) of the Social Security Act.

⁴ Department of Health and Human Services, Medicare Learning Network, “Medicare Shared Savings Program and Rural Providers”, May 2011.

⁵ Proposed Rule, Federal Register, page 19531, April 7, 2011.



system providers and their patients, critical elements of the ACO may indeed not work to advance the health of American Indian and Alaska Native (AI/AN) communities, but in fact could inadvertently hinder it.

2. PRINCIPAL FINDINGS.

The Proposed Rule for the establishment and operation of Accountable Care Organizations (ACO) under the Medicare Shared Savings Program presents a potential opportunity for improving the health status of American Indians and Alaska Natives. But the Medicare Shared Savings Program, including the requirements associated with the establishment of eligible ACO entities as well as the quality performance standards and other criteria used to determine the distribution of shared savings and losses, does not appear to be implemented with sufficient consideration to the dynamics and conditions existing in American Indian and Alaska Native communities.

Significant additional consultation and input is necessary in order for tribal representatives to fully understand the proposed requirements and for tribal representatives and CMS staff to sufficiently understand the potential impact of the Proposed Rules on American Indians and Alaska Natives (AI/AN).

Ultimately, in order to fully address the dynamics found in many AI/AN communities, the ACO model may be found not to be suitable, and there may be a need to pursue alternative approaches through the Medicare Innovations Center in order to achieve the objectives of the Medicare Shared Savings Program. In particular, there is a need to develop models that accommodate the extremely underfunded rural and frontier areas found in Indian Country.

The proposed criteria pertaining to the management and coordination of care may have the effect of largely excluding the Indian health system from leading, as well as possibly participating in, ACOs.

In addition, the criteria to be established by the Secretary pertaining to quality performance standards and the potential payment of shared savings may not be sufficiently flexible to accommodate the factors in place in AI/AN communities.

NIHB is limiting its comments primarily, but not solely, to broad issues impacting the ability of Indian health system providers to form an ACO or to participate in an ACO, and to factors that may limit or impede the ability of Indian health system providers to continue to build a revenue base that is sufficient to adequately serve AI/AN. Both sets of issues raise concerns over whether the Proposed Rule will further – or hinder – the efforts of the Indian health system to improve the coordination and quality of care provided to AI/AN.

3. ANALYSIS.

3.1 IHS and Tribal Health Programs Are Central to Serving the Needs of American Indians and Alaska Natives

The Indian health system is comprised of health programs operated by the Indian Health Service (IHS), Indian Tribes and tribal organizations, and urban Indian organizations (collectively called "I/T/U"). The IHS and tribally-operated programs supply essential health services to 1.9 million AI/AN on or near reservations and tribal communities in 35 states.⁶ An additional 46,000 AI/ANs receive medical and public health services from 34 urban Indian organizations supported by Federal funds.⁷

The services provided by the Indian health system are provided through facilities operated by the Indian Health Service and Indian Tribes and tribal organizations. As shown in Table A, the I/T/U system is comprised of a total of 45 hospitals and nearly 600 non-hospital facilities.

Table A: Total Number and Type of IHS and Tribal Health Facilities⁸

	Hospitals	Alaska Village Clinics	Health Centers	Health Stations	School Health Centers
IHS	28	N/A	58	31	2
Tribal	17	166	235	92	13

There is a need to supplement the I/T/U-provided services with additional health care services. For example, in some areas of the country, such as California, there is no IHS or tribal hospital. All inpatient hospital services provided to American Indians and Alaska Natives in California are provided by non-I/T/U providers. The Indian health system secures these supplemental services through a "contract health services" mechanism. The access of American Indians and Alaska Natives to the IHS-funded "contract health services" is coordinated by IHS and/or tribal representatives in order to prioritize the use of the funds.

As a result, today IHS, Tribes and tribal organizations coordinate health care service networks serving American Indians and Alaska Natives that encompass providers beyond the Indian Health Service, Tribes and tribal organizations, and urban Indian providers.

The proposed requirements pertaining to forming an ACO or participating in an ACO are likely beyond the reaches of many individual I/T/U providers due to current structure of services and capacity. Likely, only a few Tribes or consortium of Tribes may have the delivery capacity to qualify as an ACO. In addition, the Proposed Rule may require I/T/U

⁶ Indian Health Service, *Fiscal Year 2011 Budget Justifications*, at CJ-57.

⁷ *Id.*, at CJ-123.

⁸ Data on the total number of IHS and tribal facilities as of October, 2010 cited from IHS FY12 budget request, page CJ-182.

providers to alter the legal structure of the arrangements between providers in their current networks. Due to the funding and delivery system structures that rely on a combination of direct health services provided by the I/T/U and contract health services provided by outside providers, I/T/U providers may not be able to guarantee reaching savings requirements and other benchmarks. And given that federally qualified health centers (FQHCs), as indicated in the Proposed Rule, are not able to form ACOs but solely to participate in ACOs established by others, I/T/U providers that are FQHCs could lose substantial autonomy and control over care delivered in a culturally competent manner to their American Indian and Alaska Native patients.

3.2 American Indian and Alaska Native Communities Have Long Suffered from Neglect and Indifference

In a pivotal report, *“Broken Promises: Evaluating the Native American Health Care System”*, prepared by the U.S. Commission on Civil Rights in 2004,⁹ the health status of American Indians and Alaska Natives was documented as was the paucity of resources to address and reverse the poor conditions in many American Indian communities. Some of the findings of the U.S. Civil Rights Commission’s 2004 report were:

This fact-finding process resulted in the discovery of compelling evidence that disparities in the health status and outcomes of Native Americans persist four years after the Commission’s 1999 report titled *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality*, and after many years of periodic reporting and monitoring of the health disparities experienced by Native Americans and people of color.¹⁰

...

Even with program-level funding boosted by third-party collections the end result is a rationed system. IHS acknowledges this reality in its budget justification, explaining that its system “explicitly rations care, deferring and denying payment for medical services that are thought to be of lower priority.”¹¹

...

In the end, as a result of our examination of the Native American health care system and the nature of historical relationship between tribes and the federal government, it is possible to reduce this report to a single compelling observation. That observation is that persistent discrimination and neglect

⁹ <http://www.ihs.gov/MedicalPrograms/MCH/M/documents/BrokenPromises.pdf>

¹⁰ U.S. Commission on Civil Rights, *“Broken Promises: Evaluating the Native American Health Care System”*, July 2, 2004, page 2.

¹¹ HHS, *FY 2005 Indian Health Service Justification of Estimates for Appropriations Committees*, p. IHS-2, cited in *Broken Promises*, page 86.

continue to deprive Native Americans of a health system sufficient to provide health care equivalent to that provided to the vast majority of Americans.¹²

These findings, though, were largely not new. Sadly, many of the findings of the *Broken Promises* report in 2004 mirrored the substance of a 1928 report issued by the Meriam Commission. The 1928 Meriam Commission report declared that:

The health of the Indians as compared with that of the general population is bad. Although accurate mortality and morbidity statistics are commonly lacking, the existing evidence warrants the statement that both the general death rate and the infant mortality rate are high . . . The prevailing living conditions among the great majority of the Indians are conducive to the development and spread of disease. With comparatively few exceptions, the diet of the Indians is bad . . . The housing conditions are likewise conducive to bad health . . . The inadequacy of appropriations has prevented the development of an adequate system of public health administration and medical relief work for the Indians . . . The hospitals, sanatoria, and sanatorium schools maintained by the Service, despite a few exceptions, must be generally characterized as lacking in personnel, equipment, management, and design.¹³

There is substantial evidence that progress is being made in American Indian and Alaska Native communities across the United States in addressing these deficiencies. For example, there have been significant decreases in mortality rates among AI/AN; for example, since 1973 mortality rates have decreased about 89 percent for tuberculosis, 79 percent for cervical cancer, 38 percent for maternal deaths, and 56 percent for accidental deaths.¹⁴

Furthermore, these historic political, social, and economic conditions are affecting the health of American Indian and Alaska Native people today. In addition to the provision of more and better health services, it may take actions to address economic opportunity and to overcome historical and intergeneration trauma before improvements can be seen in the health of populations. For this reason, it may be a mistake to pre-condition funding on health outcomes of a population. One of the areas of greatest progress that is being made is the exercise of tribal sovereignty, which gives tribes control over the delivery of health services to their tribal members. Any changes in CMS policy that results in channeling tribal

¹² *Broken Promises*, page 6.

¹³ Meriam Commission, "The Problem of Indian Administration" (Report of a Survey made at the request of the Honorable Hubert Work, Secretary of the Interior, and submitted to him, Feb. 21, 1928) Chapter I, <http://www.alaskool.org/native_ed/research_reports/IndianAdmin/Chapter1.html#chap1> (last accessed Feb. 3, 2004).

¹⁴ U.S. Department of Health and Human Services National Tribal Budget Recommendations for the Indian Health Services, Fiscal Year 2013 Budget, page 7.

members into other health care delivery systems or diminishes the ability of tribes to provide health services, would ultimately be detrimental to the health of the population.

But these improvements are far from complete, and there is a substantial risk that both these advances and fulfillment of current opportunities could be lost if funding or other infrastructure is disrupted. These disruptions could be the result of considered program changes or simply neglecting to fully consider the impact of a proposed change on Indian Country. It is critical that delivery system and payment reforms that are being considered for non-American Indian communities be proactively evaluated and understood prior to requiring their adoption and implementation in Indian Country.

3.3 Indian Country Is Characterized by a Low Concentration of Medicare Beneficiaries, High Patient Acuity, a Deficiency of Providers, and Chronic Underfunding.

The following data provides a snapshot of the current conditions in Indian Country and with American Indians and Alaska Natives that generate challenges to greater coordination in health care delivery and lower overall billings for needed health care services. The lack of a concentration of Medicare beneficiaries is one such challenge when trying to meet the ACO rule of a minimum of 5,000 Medicare beneficiaries associated with an ACO. The greater overall acuity and morbidity of the AI/AN population, both on and off Medicare, is a second challenge if I/T/U providers were to attempt to lower overall health care expenditures under a Medicare Shared Savings initiative at the same time they were attempting to more comprehensively address the chronic conditions of many AI/AN.

Medicare Enrollment. As shown in Table C, American Indians and Alaska Natives total 169,460 nationally. Of this total, 139,363 (or 82%) of AI/AN Medicare beneficiaries reside in HIS service areas, with the remaining 30,097 (or 18%) of AI/AN Medicare beneficiaries in urban areas. AI/AN Medicare beneficiaries comprise only a small fraction (0.37%) of the total number of Medicare beneficiaries.

Table C: AI/AN Medicare Enrollees in Each Eligibility Group in Urban and IHS Service Areas¹⁵

Eligibility Group	Urban Areas		IHS Areas		Total Medicare Beneficiaries	
	Number	Percent	Number	Percent	Number	Percent
Total Enrollees	30,097	100.0%	139,363	100.0%	169,460	100.0%
Aged	20,399	67.8%	100,969	72.5%	121,368	71.6%
Disabled	9,545	31.7%	37,801	27.1%	47,346	27.9%
ESRD-only	153	0.5%	639	0.5%	792	0.5%

Total Medicare beneficiaries: 45,589,141
AI/AN as a percentage of total Medicare beneficiaries: 0.37%

¹⁵ California Rural Indian Health Board, American Indian and Alaska Native, Medicare Program and Policy Statistics, Summary Report, December 2009, page 54. Total Medicare beneficiaries cited from <http://www.statehealthfacts.org/comparetable.jsp?ind=290&cat=6>

Eligibility for Disabled. More than a quarter (28%) of AI/AN Medicare beneficiaries were entitled to Medicare because of prolonged disability. This is a considerably higher proportion than the 16% figure for all Medicare beneficiaries.¹⁶

Managed Care Enrollment. The managed care coverage rate for AI/AN Medicare beneficiaries residing in the IHS service areas is much lower – less than half – than the national rate for all Medicare beneficiaries, with an average managed care enrollment rate of 8.1% for AI/AN in the IHS service areas.¹⁷ However, in urban areas, managed care coverage for AI/AN under Medicare is similar to that of the Medicare population as a whole. The rate of 19.1% managed care coverage for AI/AN enrollees was essentially the same as the rate of 19.8% for all Medicare enrollees nationally.

Overall Health Status of Indian Communities. Despite the advances in health status achieved in Indian communities over the past 30 years, AI/AN communities face many health challenges including higher mortality rates for tuberculosis, chronic liver disease and cirrhosis, accidents, diabetes, suicide, and homicide, compared with other racial and ethnic groups.¹⁸

Select Health Statistics of American Indians and Alaska Natives. The rates of diabetes for AI/AN are the highest in the U.S., with diabetes rates reaching 60% of the adult population in some tribal communities.¹⁹ The rate of cancer deaths has been declining since 1990 among the U.S. population in general, but it has been increasing among AI/AN. AI/AN have higher mortality rates than the general population from specific cancers and have more devastating outcomes after diagnosis.²⁰ Cardiovascular disease (CVD) is the leading cause of death in AI/AN adults. CVD rates are on the rise among Indian people, compared to a decline in the rest of the U.S. population. The prevalence of CVD factors (hypertension, current cigarette smoking, high cholesterol, obesity, and diabetes) among AI/AN is significant, with 63.7% of AI/AN men and 61.4% of AI/AN women having one or more CVD risk factors.²¹

Impact of Lack of Access to Needed Health Care Services. Limited access to cancer screening and lack of specialized care contribute to the increasing cancer mortality rate.²²

¹⁶ *Ibid*, page 62.

¹⁷ *Ibid*, page 56.

¹⁸ U.S. Department of Health and Human Services National Tribal Budget Recommendations for the Indian Health Services, Fiscal Year 2013 Budget, page 7.

¹⁹ *Ibid*, page 11.

²⁰ *Ibid*, page 12.

²¹ *Ibid*, page 14.

²² *Ibid*, page 12.

3.4 Third Party Billing Comprises a Significant Portion of the Indian Health System Funding, but a Nearly Indiscernible Share of CMS Expenditures

Over the past several years, the Indian Health Service, Tribes and tribal organizations, and urban Indian organizations have been working to expand the pool of resources available to fund health service delivery for American Indians and Alaska Natives. These I/T/U providers have been increasingly billing Medicare, Medicaid, and more recently private, third party insurance to provide reimbursement for health care services rendered to their patients.

In Table B, annual third party revenues generated by IHS in FY 2005 and FY 2010 are shown. The vast majority of these third party revenues were received from Medicare and Medicaid. In FY 2005, \$598 million in third party revenues were secured to fund IHS services. By FY 2010, this figure is estimated to have risen to \$829 million. The increase over the FY 2005 to FY 2010 period equates to an average annual increase of 6.75% in IHS-generated third party revenues.

**Table B: IHS Funding: Appropriations and Third Party Revenues;
Comparison to CMS Budget**^{23, 24, 25, 26, 27, 28}

(figures in millions)	All Third Party Revenues	IHS Appropriations	Total IHS Annual Budget	IHS Third Party Revenue as Percentage of Total IHS Budget	Centers for Medicare and Medicaid Services Annual Budget	IHS Third Party Revenue as Share of CMS Budget
FY 2005	\$598	\$3,100	\$3,698	16.2%	\$473,000	0.13%
FY2010~	\$829	\$4,050	\$4,879	17.0%	\$747,215	0.11%

6.75% - Average annual increase in third party revenues earned by IHS (FY 2005 - FY2010).

Third party revenues – namely CMS funded programs – comprise a significant share of the IHS budget. In fact, as indicated in Table B and depicted in Chart A, by FY 2010, these third party revenues comprised nearly 17 percent (16.99%) of all IHS funding.

²³ National Indian Health Board, FY2011 Tribal Budget Recommendations to the U.S. Department of Health and Human Services, Standing on Principles: A New Era in Tribal Government Relations.

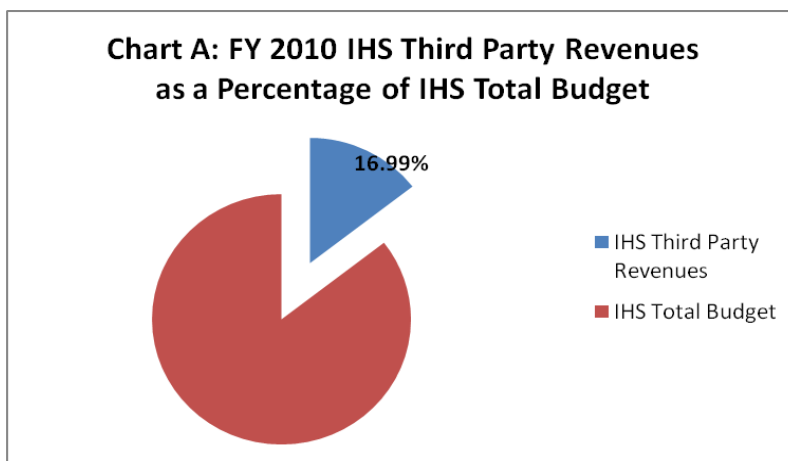
²⁴ Department of Health and Human Services, Indian Health Service, Year 2009 Profile, January 2010 (<http://iinfo.ihs.gov/Profile09.asp>)

²⁵ HHS, *FY 2005 Indian Health Service Justification of Estimates for Appropriations Committees*, p. IHS-12.

²⁶ Indian Health Service, “President’s Fiscal Year 2004 Budget Request.”

²⁷ For FY 2009 and FY 2010, Centers for Medicare and Medicaid Services, Fiscal Year 2010 Budget in Brief (<http://dhhs.gov/asfr/ob/docbudget/2010budgetinbriefk.html>)

²⁸ Centers for Medicare and Medicaid Services, Fiscal Year 2010 in Brief, viewed June 5, 2011 (<http://dhhs.gov/asfr/ob/docbudget/2010budgetinbriefk.html>)



In contrast to the relative importance CMS third party revenues are to ITU providers, tribal health programs comprise an infinitesimal share of the total health care providers, and billings, under Medicare and Medicaid. Total third party revenues generated by IHS in FY 2010 (even with non-Medicare, Medicaid and CHIP third party revenues included) is estimated to total just one-tenth of one percent (0.11%) of the annual budget of the Centers for Medicare and Medicaid Services.

Given that revenues from CMS programs comprise a significant share of the IHS budget and IHS and tribal billings comprise an infinitesimal share of the CMS budget, changes to the revenue potential from CMS operated programs will be much more acutely felt by IHS providers than by CMS itself.

In varying degrees, the Proposed Rule calls for the restructuring of payment incentives, the insertion of payment withholds and potential bonuses, and the institution of requirements for parties to share risk of losses. Each of these proposed changes could pose a level of risk to I/T/U (and other) providers that third party revenues would drop as a result.

3.5 The Third Party Billing Practices of IHS and Tribal Health Programs Have Not Yet Reached Maturity

In contrast to the general population of providers billing under Medicare (and Medicaid) today, a significant number of IHS providers have not yet reached maturity with regard to third party billing. This is the result of deficiencies in the billing practices themselves as well as lack of access to needed health care services, particularly specialized tertiary care, by AI/AN.²⁹

Any changes, especially any limitations, on the ability of tribal programs to maximize their participation in and reimbursement from Medicare could have a direct and significant

²⁹ U.S. Department of Health and Human Services National Tribal Budget Recommendations for the Indian Health Services, Fiscal Year 2013 Budget, page 12.

negative consequence on tribal health programs. For instance, if under the ACO program, revenues to tribal programs were effectively capped at current year levels with increases only accounting for program-wide inflation, the billing deficiencies would be locked in at current performance levels. This would not be in the interest of advancing the health of American Indians and Alaska Natives.

While the National Indian Health Board recognizes the need to establish more sustainable financial incentives in the American health care system in general, as the ACO initiative is attempting to do, it would be detrimental to the interests of American Indians and Alaska Natives if consideration was not given to the deficiencies in the baseline funding and expenditure levels of at least the Indian health system when fashioning a workable payment incentive program.

3.6 Associated Issues Impacting Indian Health System Providers to Form and Participate in ACO's

Comments from tribal organizations have been prepared and provided to the Federal Trade Commission and to the Internal Revenue Service on antitrust issues and considerations related to tax-exempt organizations, respectively. Attached to these comments are letters from the Alaska Native Health Consortium to both the Federal Trade Commission and the Internal Revenue Service dated May 31, 2011. Although the issues discussed in the letters are not directly in CMS's area of responsibility, these issues do impact the ability and extent to which I/T/U providers can participate in ACOs.

3.7 Additional Issues under Consideration

It could be argued that participation in ACOs is voluntary and there are good reasons for the I/T/U to abstain from participating. Furthermore, the I/T/U may be prohibited from participating in the Medicare Shared Savings Program proposed in regulations, because there are too few AI/AN beneficiaries to meet the threshold, and because most outpatient services are billed using the encounter rate. Also, participation may be prohibited in order to avoid putting federal funds at risk in the Shared Savings Program.

On the other hand, the I/T/Us have experience providing population-based services, coordinating care, using electronic medical records to generate data, establishing standards for care, and other activities that make it a good fit for the ACO model. We believe that ACO-like organizations are going to be the dominant form of payment for both Medicare and Medicaid in the future, and it is important to lay the groundwork now to assure that the I/T/U can benefit from ACOs and not be hurt by them. These are the first regulations issued by CMS about ACOs and they will set a precedent that will affect the future beyond the Medicare Shared Savings Program.

The I/T/Us need more information to be able to conceptualize how health care for AI/AN could be affected by ACOs. For example, will I/T/Us need to be members of ACO

networks in order to assure that they receive maximum payment for the services they provide to AI/AN? Will I/T/Us be penalized if the health of their populations does not improve due to issues unrelated to the quality of health services provided? Will I/T/Us be locked into an inadequate level of funding that prevents them from making progress in the improvement of the health of populations they serve? If the Indian health system formed its own nationwide ACO, would the baseline for performance measures be different than if I/T/Us were rolled into ACOs that comprised geographic areas within states? If they were enrolled in state-run ACOs, what uniform assurances would be in place to protect cultural competency in AI/AN health care?

Unlike large hospital and insurance networks throughout the United States that are staffed to respond to initiatives like the Shared Savings Program, the I/T/U administrative funding is inadequate to hire in-house experts to track trends such as ACOs and analyze the potential costs and benefits. We need to work with CMS – and CMS to engage in proactive outreach to I/T/U – to have a better understanding on both sides about how to proceed.

3.8 Tribal Consultation

Congress recently affirmed that the United State owes a special trust responsibility and legal obligation to ensure the highest possible health status for American Indians and Alaska Natives, to provide all resources to effect that policy, and to ensure that the United States works in a government-to-government relationship to ensure quality health care for all AI/AN.³⁰ President Obama, as well, similarly renewed this commitment to the government-to-government relationship between the United States and the Tribes in his November 5, 2009, Memorandum on Tribal Consultation that pronounced tribal consultation to be “a critical ingredient of a sound and productive Federal-tribal relationship.” The Presidential Memorandum also directs all federal agencies to fully implement President Clinton’s Executive Order 13175 on “Consultation and Coordination with Indian Tribal Governments” which requires establishment of “regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications.” In addition, under the Tribal Consultation Policy of HHS, “It is HHS policy that consultation with Indian Tribes will occur to the extent practicable and permitted by law before any action is taken that will significantly affect Indian Tribes.”

Even if it were not required by law, ongoing and extensive consultation with Tribes and tribal representatives is warranted in this instance (i.e., the implementation of Accountable Care Organizations) in order to develop sound policy.

The issues presented in the Proposed Rule, and in related Shared Savings Program initiatives and other Medicare payment reform initiatives, are tremendously complex and inter-woven. For those serving American Indians and Alaska Natives, this is compounded by the fact that the Indian health system has numerous unique aspects, has been and

³⁰ 25 U.S.C. § 1602.

continues to be chronically underfunded when compared to benchmark spending for other populations, is challenged by communities with levels of patient acuity that are some of the highest in the country, and the remoteness of many communities makes it difficult to serve them even when not engaged in major system changes.

Given this range of considerations, NIHB urges CMS to immediately engage in a meaningful and structured tribal consultation process to gain a better understanding in Indian Country of how the implementation of the Proposed Rule may impact the ability of tribal organizations to serve their American Indian and Alaska Native patients. This will require a two-way exchange of information.

In addition, we recommend that this consultation consider not just the current Proposed Rule but also other payment reform initiatives underway by CMS, such as the Medicare Inpatient Hospital Value-Based Purchasing and the payment initiatives related to the bundling of acute and post-acute services. I/T/U management would benefit from additional outreach and education by CMS about ACOs and other payment approaches that are currently under development. We hope that these comments from NIHB and the comments from Tribes and other tribal organizations can serve as a basis for more significant discussion.³¹ NIHB is ready to provide any assistance you may need to formulate an efficient consultation process.

3.9 Conferring with Urban Indian Organizations

Section 514 of the Indian Health Care Improvement Act (25 U.S.C. 1660d), signed into law on March 23, 2010 as part of the Patient Protection and Affordable Care Act, requires the Department of Health and Human Services to confer with Urban Indian Health Programs receiving funding under Title V of the Indian Health Care Improvement Act (IHCA) when carrying out actions and programs which may have a critical impact upon urban Indian communities. As the issues under consideration in the Proposed Rule present many potential challenges and give rise to many changes which could adversely impact the provision of health care services to urban Indians, NIHB urges CMS to confer with the National Council of Urban Indian Health and its 36 member organizations in a manner which “emphasizes trust, respect, and shared responsibility”.³² Urban Indian Health Programs are a critical component of the health delivery system for Indians, and they must be conferred with in order for the Federal government's trust responsibility to be fulfilled to Indians without regard to where they reside.³³

³¹ We wish to call your attention to the companion comments prepared and submitted to CMS by the Alaska Native Tribal Health Consortium involving more directed concerns regarding the drafting of the Proposed Rule.

³² 25 U.S.C 1660d (2010)

³³ The Supreme Court has acknowledged the duty of the Federal government to Indians, no matter where located: “The overriding duty of our Federal Government to deal fairly with Indians wherever located has been recognized by this Court on many occasions.” *Morton v. Ruiz*, 415 U.S. 199, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974) (emphasis added), citing *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942); and *Board of County Comm’rs v. Seber*, 318 U.S. 705 (1943).

Analysis of Proposed Rule for Implementation of Section 3022 of ACA:
Accountable Care Organizations (CMS-1345-P)

Attachments:

- Letter from Alaska Native Health Consortium to Internal Revenue Service, Comments on Notice 2011-20, May 32, 2011
- Letter from Alaska Native Health Consortium to Federal Trade Commission, Comments on Proposed Statement of Antitrust Enforcement Policy Regarding ACOs Participating in the Medicare Shared Savings Program, Matter V100017, May 31, 2011