Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 926 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

Delivered Electronically

May 26, 2011

Dr. Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-08010

Subject: TTAG Statement on May 13 All Tribes Call Regarding Eligibility of FQHCs that are Tribal Clinics to Electronic Health Record Incentive Payments

Dear Administrator Berwick:

On behalf of the Tribal Technical Advisory Group to the Centers for Medicare and Medicaid ("TTAG"), I am writing to provide a written statement of my comments given on the May 13, 2011, Center for Medicare and Medicaid Services (CMS) All Tribes call. The purpose of the call was to enter into a discussion and receive tribal input on the issue of eligibility of Federally Qualified Health Centers (FQHCs), inclusive of tribal clinics, for electronic health record (EHR) incentive payments.

My statement on the All Tribes call and the statement of another TTAG member (Jim Roberts) are attached. In brief, the statements indicate we believe that CMS should treat all facilities that meet the Medicaid definition of FQHCs as FQHCs for purposes of implementing the Medicaid EHR incentive payments under section 4201 of the American Recovery and Reinvestment Act. To do otherwise would result in a significant number, possibly a majority, of tribal clinics not qualifying for the incentive payments.

We appreciate your consideration of this TTAG analysis and recommendations. We urge CMS to take the actions requested. We are available at any time to provider further clarification on these issues as may be needed.

Sincerely,

Valerie Davidson, Chair

cc: Kitty Marx, Director, Tribal Affairs Group, CMS
Cindy Mann, Director, Center for Medicaid and State Operations
Jackie Garner, Jessica Kahn, and Michelle Mills, CMCS/CMS

May 13, 2011
Statement of Valerie Davidson
Chair, Tribal Technical Advisory Group to CMS[1]

CMS All Tribes Call on the Electronic Health Records Incentive Payment Program and Treatment of Tribal Programs: Access to incentive payments for FQHCs that are tribal clinics being paid other than under a State's FQHC reimbursement rate

We are very pleased that this All Tribes call was scheduled. Initially, we were disappointed and surprised that CMS published a position on the topic of incentive payments to tribal health programs before discussing the issue with the TTAG and engaging in consultation with tribes and tribal health programs. We are heartened, though, to understand that CMS has not closed this issue, and this call is on an opportunity to consider an open policy issue and that the advice of tribal representatives is being sought.

I believe we share a starting point on this issue, which is that improvements in Indian health and reductions in health status disparities to which we are all committed cannot occur if the tribes and tribal health programs are excluded from critical opportunities for improvement.

We appreciate the clarity in the CMS notice for this conference call, which stated, "Tribal and urban clinics fall within the definition of an FQHC under section 1905(l)(2)(B) of the Social Security Act."

Section 4201 of the Recovery Act, which established the Medicaid EHR incentive payment program, lists four types of "eligible professionals" (i.e., a provider eligible for Medicaid incentive payments). One of these four types is a professional that a) "predominantly practices in an FQHC…" and b) "has at least 30% of the professional's patient volume attributable to needy individuals."

As CMS recognized in its notice, *all* Tribal and urban clinics are FQHCs. So, we believe the ARRA provision to mean that tribal clinics should be able to use the "30% needy" criterion when determining if they qualify for the EHR incentive payments.

CMS then argues, though, that it must consistently apply its payment policies, and so, "tribal clinics may choose between being reimbursed for health care services as an IHS facility or an FQHC.... If tribal clinics elect to be reimbursed as an IHS facility (or any method other than the FQHC reimbursement rate), they will not be treated as FQHCs for this program."

In making this argument, CMS states that consistency in payment for health care services must be maintained by sticking with one payment method or another. But, the HIT incentive payments are not "payment for health care services." Section 4201(a)(2) of the ARRA states, "the payments described in this paragraph [are] to encourage the adoption and use of certified EHR technology..." These payments are not for health care services but for the adoption of health information technology.

It would not be inconsistent for CMS to add the HIT incentive payments to whatever payment vehicle is in place (whether an FQHC method or otherwise). This type of structure is used in a variety of instances

[1] Sec. 5006(e) of the American Recovery and Reinvestment Act codifies in statute, at sections 1902(a)(73) and 2107(e)(1)(C) of the Social Security Act, the requirement for the Secretary of Health and Human Services to maintain a Tribal Technical Advisory Group within CMS and the requirement that States seek advice from Tribes on a regular and ongoing basis where one or more Indian health program or urban Indian organization furnishes health care services.

under State Medicaid payment policies.[2] In fact, CMS's application of the HIT incentive payment program WOULD BE CONSISTENT if it treated all entities that are FQHC's (including tribal clinics) similarly as FQHC's. On its face, the underlying law itself seems to call for this.

Again, in the explanation that CMS distributed on this issue, "payment consistency" is a primary concern. But as CMS determines whether a policy is consistent or not, it is critical that it consider why the criterion of being an FQHC (i.e., "primarily practicing in an FQHC") was included in ARRA section 4201. The FQHC criterion was included to identify the type of facility (and thereby infer about the intensity of the low-income/uninsured patient population it serves) not the payment mechanism of the facility. FQHCs – and in particular FQHCs that are tribal clinics – have a greater intensity of non-Medicaid enrolled low-income individuals than do providers at large. And so, if the law included only the general eligibility criterion alone ("have equal to or greater than 30 percent Medicaid patient volume") the law would have inadvertently excluded a provider group (FQHCs) that needs the HIT incentive payments the most. The law's inclusion of the FQHC-specific criteria prevents such an inadvertent result. But, if CMS were to remove the FQHC designation for tribal clinics for purposes of implementing ARRA section 4201, this "inadvertent" result would actually happen. There are a number of providers on this call that can provide facility-specific data indicating they would not be able to qualify under the "equal to or greater than 30% Medicaid" criterion.S

Further, under ARRA, only FQHCs may receive incentive payments for physician assistants. Despite the fact that tribal health programs are FQHCs according to the statutory definition, and already face daunting recruitment challenges due to their small size and remote locations, CMS's interpretation will prevent them from having the extremely important advantage of getting incentives for certain physician assistants.

Given the clear congressional intent and plain language of the authorizing law and, considering the significant negative impact on tribal clinics achieving meaningful use, we request that CMS treat all facilities that meet the Medicaid definition of FQHC as FQHC's for purposes of implementing ARRA section 4201.

Jim Roberts will provide some on-the-ground examples of what the exclusion of tribal clinics from using the "30% needy" criterion would mean.

Before Jim provides these data, I would like to conclude by just emphasizing the special Trust Responsibility and legal obligations owed by the Federal government to Alaska Natives and American Indians that was most recently acknowledged by the Congress in the Affordable Care Act's reauthorization of the Indian Health Care Improvement Act. A decision by CMS that will deprive a significant percentage, if not a majority of tribal health programs, of the meaningful use incentives that may be the only financial resources available to them to try to achieve these objectives would be completely inconsistent with this special Trust Responsibility of the United States.

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[2] Under various Medicaid State Plans, payments to providers for health care services are supplemented by payments for non-health care services. For example, for inpatient hospitals this occurs under Medicaid with regard to 1) payment for capital, 2) payment for direct medical education expenses, and 3) disproportionate share hospital payments. Depending upon the circumstances, the supplemental (non-health service) payments are made on a prospective or cost-based without regard to whether the provider may have elected to receive the underlying payment for health services on a prospective, cost-based, or other methodology.

Statement of Jim Roberts
Policy Analyst, Northwest Portland Area Indian Health Board
Member, Tribal Technical Advisory Group to CMS

NPAIHB has completed a review of sixteen tribal health programs, which comprise approximately 40% of all the Indian health programs in the Portland Area.

These programs provide primary care services to a range of community sizes that span a range of user population from 300 to 6,300 AI/AN beneficiaries. These programs are often located in the most remote and rural areas of Idaho, Oregon and Washington states and are often the only health care providers in their tribal community.

Our review indicates that presently only 4 of these 16 programs would be able to meet the Medicaid patient volume requirements to participate in the incentive program. Of these four programs, one would likely not qualify in certain months or quarters because they are right on the cusp of meeting the 30% Medicaid patient volume requirement. If this program was not included this would mean only 18% of our Tribal health programs in the Portland Area would be eligible to participate in the Medicaid incentive program.

The data on these programs in the Portland Area is not that different than the situation than what the data will likely be for the rest of Indian Country. Particularly in those Areas like the California, Nashville, and Bemidji Areas where you have very small sized Tribal health programs that are remotely situated that serve very isolated users.

Based on our data, unless IHS and Tribal programs are allowed to use the needy individual criterion to meet the requirements of participating in the Medicaid incentive program, it is likely that CMS will lock out over 75% of all Indian health programs from participating in a program intended to develop EHR in small group setting like many of the programs within the Indian health system. Thanks, Val.

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