

September 8, 2015

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1631-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Comments on CMS-1631-P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 – Grandfathered Tribal FQHCs

I. Introduction.

The Tribal Technical Advisory Group (TTAG)¹ offers the following comments on the provisions of CMS-1631-P, “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016”² that address “grandfathered tribal federally-qualified health center” (FQHC) designation. We are very concerned by, and strenuously object to, the proposal by the Centers for Medicare and Medicaid Services (CMS) to withdraw grandfathered Medicare provider-based status for certain tribal facilities and instead offer a new and untested grandfathered tribal FQHC status. The proposed change is legally unnecessary, inexplicably reverses CMS’s nearly two decade history of interpreting and applying the regulation that establishes grandfathered provider-based status,³ and, if adopted, would disrupt operations at the affected tribal facilities, dramatically lower their reimbursement rates, and potentially disqualify them from receiving any Medicare payments whatsoever between the (unidentified) time they lose their grandfathered provider-based status and the time they qualify for the grandfathered tribal FQHC designation. We are also disappointed by the extent and quality of tribal consultation that has occurred to date.

If CMS is concerned that some regulatory change is needed to ensure that the associated IHS or tribal hospitals are not at risk of losing their Medicare certification because of their

¹ The TTAG advises the Centers for Medicare and Medicaid Services on Indian health policy issues involving Medicare, Medicaid, the Children’s Health Insurance Program, and any other health care programs funded (in whole or in part) by CMS. In particular, the TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives under these federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations.

² 80 Fed. Reg. 41,686 (July 15, 2015) [hereinafter “Proposed Rule”].

³ 42 C.F.R. 413.65(m).

affiliation with a grandfathered tribal facility (the only stated reason for the proposal, and a concern we believe is unfounded), it should address that concern directly and simply, by clarifying that such an affiliation does not place the hospitals out of compliance with the relevant hospital Conditions of Participation (COPs). Instead, CMS's proposal would force tribal facilities into a new and poorly-understood FQHC designation that may not fit their administrative and clinical operations and that will almost certainly reduce their Medicare reimbursement. If CMS believes that the proposed grandfathered tribal FQHC status may actually be beneficial for some tribal facilities (because in some respects FQHC services and coverage may be broader than for provider-based facilities), it could make that status *optional* for eligible facilities and allow them a reasonable period of time to compare the alternatives and make an informed choice.

For these reasons and as we explain further below, we respectfully ask that CMS withdraw the proposal in its entirety, or make the new tribally-grandfathered FQHC status optional for eligible tribal facilities. If CMS instead decides to go forward with its proposal, we ask that there first be additional tribal consultation, and that the proposal be revised to address our concerns and to allow a smooth transition to the new FQHC status for affected programs, including a guarantee that no facility will be required to forego reimbursement at any time during or after the transition. We also ask that CMS take immediate action to extend grandfathered provider-based status to certain tribal facilities in Oklahoma, and perhaps other locations, which were mistakenly denied that status because of errors committed by federal agencies.

II. Discussion.

1. Tribal consultation has been inadequate given the breadth of the proposed program changes.

In discussions with the TTAG and in the Proposed Rule, CMS has said that the proposed change is needed to ensure that IHS hospitals do not lose their Medicare certification due to the fact that their affiliated tribal facilities cannot meet the administrative and clinical integration requirements of 42 C.F.R. § 482.12 related to the requirements for a hospital governing body that would otherwise be required for provider-based status.⁴ We think that concern – which flies in the face of decades of administrative practice and the plain language and purpose of the applicable regulation – has no foundation as a matter of law. At CMS's specific request, the TTAG spent considerable time and resources drafting a legal memorandum that explains why current law authorizes tribal clinics to maintain grandfathered provider-based status and why their associated hospitals maintain Medicare certification even absent administrative or clinical integration. We anticipated CMS would study that memorandum and give it due consideration before issuing a Proposed Rule that, in our view, seeks to resolve a problem that does not exist. Instead, CMS released the Proposed Rule essentially simultaneously after receiving the requested TTAG memorandum, without prior tribal consultation or consideration of the TTAG's analysis, despite the specific request that an opportunity be provided for further discussion prior to any action.

⁴ Proposed Rule at 41,799.

We specifically incorporate that memorandum in this response, and we reiterate some of the analysis below. But the lack of meaningful collaboration on this matter is deeply concerning, and in our view warrants CMS withdrawing the proposal and engaging in further consultation before it crafts any further proposal on the same topic or releases it for public comment (something about which we elaborate later in this response). This lack of collaboration should also be addressed moving forward in order to ensure meaningful tribal response to future CMS proposals.

2. Terminology.

Because this response addresses two separate sets of Medicare COPs, as well as two different types of “grandfathered” designation, we will use the following terms throughout for the sake of consistency:

- “Part 482” refers to the Medicare hospital COPs at 42 C.F.R. Part 482, with which all hospitals generally must comply in order to retain their Medicare certification.
- “Provider-based COPs” refers to the COPs that apply to entities seeking provider-based status. These are found at 42 C.F.R. § 413.65.
- “Provider-based tribal grandfather clause” refers to the grandfather clause in the provider-based COPs that is specific to IHS and tribal facilities (collectively, I/T facilities), 42 C.F.R. § 413.65(m).⁵

⁵ The grandfather clause reads as follows:

(m) Status of Indian Health Service and Tribal facilities and organizations. Facilities and organizations operated by the Indian Health Service or Tribes will be considered to be departments of hospitals operated by the Indian Health Service or Tribes if, on or before April 7, 2000, they furnished only services that were billed as if they had been furnished by a department of a hospital operated by the Indian Health Service or a Tribe and they are:

(1) Owned and operated by the Indian Health Service;

(2) Owned by the Tribe but leased from the Tribe by the IHS under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes: or

(3) Owned by the Indian Health Service but leased and operated by the Tribe under the Indian Self-Determination Act (Pub. L. 93-638)

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

- “Grandfathered provider-based tribal” facilities or clinics refers to tribal clinics that bill as provider-based entities by virtue of satisfying the provider-based tribal grandfather clause.
- “Grandfathered tribal FQHC” refers to the new FQHC designation that CMS sets out in the Proposed Rule as an alternative to grandfathered provider-based tribal status in some cases. This does *not* refer to any current FQHCs that are operated by tribes or tribal organizations under existing law.

3. Grandfathered tribal provider-based status is already guaranteed under existing law and does not jeopardize the Medicare certification of associated IHS hospitals.

At the outset and as explained in the TTAG’s previous legal memorandum, the Proposed Rule is offering a solution to a problem that does not exist. That is, CMS specifically designed the grandfathered provider-based tribal facility clause so that I/T facilities could qualify as provider-based *despite* not being able to comply with the integration requirements at 42 C.F.R. § 482.12, and has never suggested otherwise in subsequent amendments to the provider-based regulations.⁶ We elaborate below.

a. The regulatory history demonstrates that CMS intended to allow IHS and tribal facilities to qualify for grandfathered provider-based status even absent the hospital integration required under 42 C.F.R. § 482.12.

When CMS first initiated rulemaking on the provider-based regulations in 1998, the proposal did not include any special provisions concerning I/T facilities. Rather, CMS suggested that “all facilities or organizations”⁷ seeking provider-based status would have to fulfill the same

in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes.

⁶ See, e.g., Medicare Program; Prospective Payment System for Hospital Outpatient Services, 63 Fed. Reg. 47,552 (Sept. 8, 1998) (proposing provider-based system) [hereinafter “1998 Proposed Rule”]; Office of Inspector General; Medicare Program; Prospective Payment System for Hospital Outpatient Services, 65 Fed. Reg. 18,434 (Apr. 7, 2000) (establishing tribal grandfather clause to provider-based rules) [hereinafter “2000 Final Rule”]; Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates, 67 Fed. Reg. 49,982 (Aug. 1, 2002) (amending provider-based rules and explicitly keeping I/T grandfather clause intact) [hereinafter “2002 Final Rule”].

⁷ 42 C.F.R. § 413.65(d).

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

set of proposed provider-based COPs,⁸ which included the requirement that provider-based facilities be an “integral and subordinate part[] of the main provider.”⁹

In response, IHS and numerous tribal stakeholders requested an I/T exception to the proposed provider-based COPs.¹⁰ Commenters explicitly pointed out that the requirements of integrated governance between the main and satellite facilities inherently would not work in the case of “IHS facilities that are currently operated by Indian tribes under the auspices of Public Law 93–638” or the “[m]any tribes [that] have acquired operations of outpatient facilities and [were] in the process of acquiring the affiliated hospitals.”¹¹ IHS further argued that the provider-based COPs failed to account for “the statutory opportunities for self-determination by the Indian tribes,”¹² and ultimately recommended “the current [I/T] system be ‘grandfathered’ to meet the definition of provider-based entity.”¹³

CMS agreed with these commenters, stating:

The provision of health services to members of Federally recognized Tribes is based on a special and legally recognized relationship between Indian tribes and the United States Government. To address this relationship, the IHS has developed an integrated system to provide care that has its foundation in IHS hospitals. Because of these special circumstances, not present in the case of private, non-Federal facilities and organizations that serve patients generally, *we agree that it would not be appropriate to apply the provider-based criteria to IHS facilities or organizations or to most tribal facilities or organizations.*¹⁴

⁸ See generally 1998 Proposed Rule.

⁹ *Id.* at 47,588. CMS proposed additional requirements for facilities that were not on the same campus as the main provider, operated as a joint venture, sought provider-based status in relation to a hospital, or operated under management contracts. See generally 1998 Proposed Rule at 47,589-94 (codified as amended at 42 C.F.R. § 413.65(e) – (h)).

¹⁰ 2000 Final Rule at 18,507.

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.* (emphasis added).

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

In its Final Rule, CMS then added the provider-based tribal grandfather clause to the provider-based COPs in acknowledgment of the impossibility of integration between IHS and tribal facilities.

This exception for I/T facilities makes sense, as requiring integration between the ownership, management, staff, and operations of the main and provider-based facilities literally cannot be achieved when IHS operates the main hospital and a tribe, under a self-determination contract or compact, operates the provider-based clinic, or vice versa.¹⁵ In these cases, the main hospital and the provider-based I/T clinic will have separate governance structures and staffs, will not be able to demonstrate shared management, and could never satisfy the provider-based COPs: the two facilities are run by two entirely separate entities. As a result, and in light of the regulatory history cited above, the only reasonable interpretation of the provider-based tribal grandfather clause is that CMS drafted the grandfather clause with the understanding and intent that qualifying entities be deemed provider-based regardless of whether they satisfied the integration COPs.¹⁶ Indeed, the agency has subsequently confirmed this understanding of the situation.¹⁷

The Center for Medicare Management (CMM) underscored this reading of the provider-based tribal grandfather clause in a Frequently Asked Questions (FAQ) guidance issued in 2003.¹⁸ In the FAQ, CMM included the following example of an arrangement that would satisfy the provider-based tribal grandfather clause:

For example, on April 7, 2000 a particular hospital and a clinic aligned with it may both have been operated by the IHS, but since that date the operational responsibility for the hospital may have been assumed by the Tribe under the

¹⁵ Or in a third scenario, one Tribe or tribal organization has assumed a former IHS operated hospital, while another Tribe or tribal organization has assumed operation of a former IHS operated clinic that had been provider-based to the hospital.

¹⁶ In addition, requiring grandfathered provider-based tribal facilities to satisfy the integration requirements would render 42 C.F.R. § 413.65(m) a complete nullity in violation of canons of statutory construction. *See, e.g., Duncan v. Walker*, 533 U.S. 167, 174 (2001) (noting the “cardinal principle of . . . construction” that “no clause, sentence, or word shall be superfluous, void, or insignificant”) (citations and internal quotations omitted).

¹⁷ *See* Letter from Thomas L. Grissom, Director, Center for Medicaid Management, to Marti Mahaffey, Executive Vice President and COO, TrailBlazer Health Enterprises, LLC (Aug. 11, 2003).

¹⁸ CENTERS FOR MEDICARE AND MEDICAID SERVICES, CENTER FOR MEDICAID MANAGEMENT, FREQUENTLY ASKED QUESTIONS: PROVIDER-BASED STATUS FOR INDIAN HEALTH SERVICE AND TRIBAL FACILITIES 1 (Aug. 11, 2003) [hereinafter PROVIDER-BASED FAQ]. To the best of our knowledge, there has been no Tribal consultation subsequent to this letter regarding a change in the application and interpretation of the applicable regulations.

Indian Self-Determination Act (Pub.L. 9[3]-638), in accordance with applicable regulations and policies of the IHS in consultation with Tribes. Since section 413.65(m) would have extended grandfathering to such a facility if this arrangement had been in place on April 7, 2000, a change of this kind would not prevent the clinic from retaining its grandfathered status.¹⁹

As this guidance makes clear, the entire purpose of the grandfather clause is to allow I/T facilities that inherently cannot meet continuity and integration of management requirements to nonetheless qualify for provider-based status.²⁰ By recognizing that the clinic would qualify for grandfathered provider-based status in the example above, CMM effectively recognized that the provider-based tribal grandfather clause allows for certain non-compliance with the regulatory integration requirements in the provider-based COPs.²¹

b. Grandfathered provider-based tribal facilities are similarly exempt from integration requirements in Part 482.

Non-grandfathered provider-based outpatient clinics must comply with certain provisions of Part 482.²² Portions of this Part contain functionally identical integration requirements as those in the provider-based COPs from which tribal facilities are exempt under the grandfather clause.²³ Because these Part 482 integration requirements are equally impossible for grandfathered provider-based tribal facilities to fulfill, provider-based tribal facilities are equally exempt from the Part 482 integration provisions for the same reasons discussed above.

¹⁹ *Id.*

²⁰ On this point, the TTAG notes that tribes nationwide have relied on the 2003 letter as an authoritative agency interpretation of the provider-based rules as they evaluate their ability to obtain and maintain provider-based status. As CMS is presumably now rejecting the letter in formulating the Proposed Rule, it should have consulted with the TTAG and with tribes nationwide prior to completely changing its view on the law. Having failed to do so prior to publishing this proposed rule, it should now withdraw it and proceed with meaningful consultation now.

²¹ PROVIDER-BASED FAQ at 2 (noting that if a facility no longer satisfies the grandfather clause, it “may qualify for provider-based status only by showing actual compliance with the requirements in section 413.65”).

²² 42 C.F.R. § 413.65(g)(8).

²³ For instance, Part 482 requires that health care professionals at an outpatient clinic hold clinical privileges at the main hospital, 42 C.F.R. § 413.65(d)(2)(i); 42 C.F.R. § 482.54(c)(4)(i), and that the outpatient services be integrated with the inpatient services of the main hospital. 42 C.F.R. § 482.54(a).

This is reflected in the provider-based COPs themselves, which only require compliance with the main hospital's "applicable Medicare conditions of participation in 42 CFR part 482."²⁴ CMS did not mandate that hospital outpatient departments comply with "all," "each," or "every" Part 482 requirement. Rather, the agency recognized that there would be circumstances in which various provisions of Part 482 might not, for whatever reason, apply to an outpatient department, and so instead stated that outpatient departments need only comply with the "applicable" provisions of Part 482.²⁵ In the case of grandfathered provider-based tribal facilities, the Part 482 provisions that would inherently prevent an I/T facility from ever achieving grandfathered provider-based status cannot be "applicable" to such facilities.

c. Hospitals associated with grandfathered I/T facilities do not lose their right to participate in Medicare.

CMS now asserts that the lack of integration required by 42 C.F.R. § 482.12 threatens the hospital's Medicare certification.²⁶ But this interpretation effectively nullifies the provider-based tribal grandfather clause: there would be literally no way for a tribal facility to achieve grandfathered provider-based status if hospitals would lose their Medicare certification *because of their provider-based association with the tribal facility*. This is a nonsensical and impermissible reading of the regulations.²⁷

Further, 42 C.F.R. § 482.12, the only integration requirement that CMS cites in the Proposed Rule,²⁸ was adopted in 1986.²⁹ CMS was fully aware of this provision when it passed

²⁴ 1998 Proposed Rule at 47,588 (currently codified as amended at 42 C.F.R. § 413.65(g)(8) (emphasis added)).

²⁵ Given that CMS *did* incorporate the entirety of *other* regulatory provisions as part of the provider-based COPs without using any qualifying language, *see, e.g.* 42 C.F.R. §§ 413.65(e)(3)(v)(A)-(B) and (g)(1), (4), its decision to only incorporate "applicable" provisions of Part 482 must be seen as deliberate. *See, e.g., Keene Corp. v. United States*, 508 U.S. 200, 208 (1993) (noting that "where Congress includes particular language in one section of a statute but omits it in another . . . , it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion") (quoting *Russello v. United States*, 464 U.S. 16, 23 (1983)).

²⁶ Of course, as the certifying entity, CMS could very easily allow such hospitals to maintain their certification pursuant to the analysis set out in this memorandum.

²⁷ *See, e.g., King v. Burwell*, 135 S. Ct. 2480, 2496 (2015) ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter.").

²⁸ Proposed Rule at 41,799.

²⁹ Medicare and Medicaid Programs; Conditions of Participation for Hospitals, 51 Fed. Reg. 22,010-01 (June 17, 1986).

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

the provider-based tribal grandfather clause in 2000.³⁰ Its discussion in the Preamble to the Final Rule indicates it was well aware that I/T facilities would not be able to satisfy the Part 482 integration requirements, and that it saw no contradiction between the grandfather clause and the Medicare COPs. Indeed, for many years, CMS has certified IHS hospitals that associate with tribally run clinics. By now suggesting that 42 C.F.R § 482.12 requires decertification of the main hospital in these situations, CMS would needlessly and inexplicably upend the regulatory framework that allows I/T facilities to continue to qualify for provider-based status.³¹ Such an interpretation is impermissible.³²

4. CMS should withdraw the proposal, or amend the provider-based regulations to acknowledge that grandfathered provider-based tribal facilities and their associated hospitals are exempt from administrative integration requirements.

A cardinal rule for interpreting statutes is that “[a] fair reading of legislation demands a fair understanding of the legislative plan.”³³ The same is true for interpreting administrative regulations like the one that extends grandfathered provider-based status to certain I/T facilities. CMS has repeatedly acknowledged that the “legislative plan” behind that provision was to allow I/T facilities that had billed as provider-based on or before April 7, 2000 to continue to enjoy that status, even if, as a result of changing from IHS to tribal administration or vice-versa, they could no longer satisfy the administrative integration rules.³⁴

³⁰ See *Hall v. United States*, 132 S. Ct. 1882, 1884 (2012) (“Court assumes that Congress is aware of existing law when it passes legislation. . .”).

³¹ CMS is also functionally prohibiting an IHS/tribal provider-based relationship in direct contravention to the Indian Self-Determination and Education Assistance Act’s (ISDEAA’s) express goal of encouraging tribal management of IHS facilities.

³² See *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (agency interpretation that is interpretation that is “inconsistent with the regulation” should be rejected); *accord id.* at 515 (interpretation of a regulation that conflicts with an earlier interpretation is due “‘considerably less deference’ than a consistently held agency view”) (internal citations omitted); see also *Burwell*, 135 S. Ct. at 2492 (“A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme . . . because only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law”).

³³ *Burwell*, 135 S. Ct. at 2496.

³⁴ We think it is clear that this is the correct, and certainly the most natural, reading of the provider-based tribal grandfather clause, which uses the *present tense* “they are” to describe the permissible ownership and management configurations for grandfathered tribal provider-based status. To qualify for that status, the only past requirement the clause imposes is that, on or before April 7, 2000, the facility must have “furnished only services that were billed as if they had been furnished by a department of a hospital operated by the Indian Health Service or a Tribe.”

Rather than uprooting this system altogether, if CMS believes that some further clarification is required, it should amend the current provider-based tribal grandfather clause to expressly state that (1) I/T facilities qualify for grandfathered provider-based status solely by virtue of satisfying 42 C.F.R. § 413.65(m); and (2) changes in the IHS or tribal status of a hospital or facility's operation will not lead to the loss of provider-based status, or jeopardize the associated hospital's Medicare certification, if the resulting configuration would have qualified as a grandfathered provider-based tribal facility as of April 7, 2000.³⁵ We reiterate, however, that we believe no such clarification is needed. CMS could achieve the same result by simply reaffirming its longstanding reading of the regulations as stated in the Preamble to the 2000 Final Rule. Either approach would address CMS's stated concern, without doing violence to the purpose of the provider-based tribal grandfather clause or causing an upheaval in current tribal practices.

5. TTAG Comments on CMS's Proposed "Grandfathered Tribal FQHC" Rules.

If CMS remains intent on creating a grandfathered tribal FQHC status, the Proposed Rule should be revised to (1) maintain the current reimbursement methodology and rates for facilities changing their status, (2) allow a reasonable transition time and continued provider-based status pending a change to that status, (3) make the status change optional for eligible I/T facilities, and (4) clarify several aspects of the Proposed Rule, and (5) address other concerns we discuss below.

- a. **The proposed grandfathered tribal FQHC payment rates would be far lower than those for grandfathered provider-based tribal facilities; the provider-based rates should apply instead.**

CMS states in the Proposed Rule that "we are proposing that these grandfathered tribal FQHCs be paid the lesser of their charges or a grandfathered tribal FQHC PPS rate of \$307, which equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS, rather than the FQHC PPS per visit base rate of \$158.85."³⁶ At first blush, this sounds as if the grandfathered tribal FQHCs would be paid the same way as if they were still provider-based.

But in fact, grandfathered tribal FQHCs would almost certainly see a dramatic reduction in their Medicare reimbursement, both because they would be paid "the lesser of" their charges or the grandfathered tribal FQHC PPS rate, and because the FQHC PPS rates include the professional services for which provider-based tribal facilities receive separate reimbursement in

³⁵ Given the complicated regulatory cross-references in the provider-based regulations and the two sets of COPs at issue, we believe that additional collaboration between the TTAG and CMS is necessary to determine the precise phrasing of any amendments to the provider-based tribal grandfather clause or the provider-based regulations generally.

³⁶ Proposed Rule at 41,800.

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

addition to their Medicare outpatient per-visit payment. The TTAG appreciates CMS's attempt to ensure that grandfathered tribal FQHC billing rates would exceed the existing FQHC PPS rates. But should CMS continue with its proposal, grandfathered tribal FQHCs should not be forced to accept lower Medicare reimbursement, and should be able to bill and be paid at the same rates as if they were grandfathered provider-based tribal facilities.

Under current rules, grandfathered provider-based tribal clinics are paid (1) the Medicare outpatient hospital per diem rate, currently \$564 for Alaska and \$307 for the lower-48 states;³⁷ *plus* (2) Medicare physician/professional fees for covered Medicare Part B services. The per diem payment is essentially a "facility fee," separate from the professional fees, and (with a few exceptions) there is no obligation for the clinic to bill or accept less than the per diem payment for the facility's services. That means that, in the vast majority of situations, the clinic is paid at least \$564 or \$307 for all the services it provides to a patient on a given day, and in most cases it will receive significantly more because of the additional payment for the physician's professional services (which the physician assigns to the clinic).³⁸

By contrast, the grandfathered FQHC per diem rate "includes" physician and professional services, meaning these would not be separately billable in addition to the per diem rate, and total Medicare reimbursement for the clinics would go down substantially. And CMS has proposed that grandfathered tribal FQHCs be paid the *lesser* of the G-code-based "actual charge" (discussed in further depth below) or the grandfathered tribal "PPS" payment.³⁹ This means that the grandfathered tribal FQHC will only be paid at the all-inclusive hospital rate if the G-code-based charges are higher than the all-inclusive rate, rendering such rate a cap on payment, not a floor or a guarantee as it is under the provider-based payment methodology.

Moreover, the Proposed Rule is unclear whether Alaska clinics that become grandfathered tribal FQHCs would be paid at the \$564 Alaska Medicare outpatient rate, or only at the \$307 rate that applies in the lower-48 states.⁴⁰ If CMS goes forward with its proposal,

³⁷ Indian Health Service, Reimbursement Rates for Calendar Year 2015, 80 Fed. Reg. 18,639 (Apr. 7, 2015).

³⁸ *Id.*; accord 42 C.F.R. § 410.46; CENTERS FOR MEDICARE AND MEDICAID SERVICES AND NOVITAS SOLUTIONS, INDIAN HEALTH SERVICE, PART A AND PART B 78 (Jan. 2015) ("Depending on the services being performed, a provider-based clinic may submit two claims for outpatient services: one claim to Part A for the facility fee and one claim to Part B for the provider's service."). The per diem rate also "includes" labs, x-ray services, and drugs administered during a visit, which means these services are not separately paid for by Medicare, but in most cases they qualify for payment at the per diem rate even if no other services are provided that day.

³⁹ Proposed Rule at 41,800.

⁴⁰ In the Proposed Rule, CMS notes the higher rate in Alaska, 80 Fed. Reg. at 41,799, but then seems to suggest that the \$307 payment rate will apply nationwide. *Id.* at 41,799. The actual text of the proposed regulation, by comparison, potentially suggests that the Alaska rates would still apply in Alaska. *Id.* at 41,952.

Alaska facilities should certainly be paid at the higher Medicare outpatient hospital rate that reflects their higher cost of services.

Finally, although the Proposed Rule would set the grandfathered tribal FQHC PPS rate at the IHS Medicare Outpatient Hospital per diem rate for now, it also says that CMS “will monitor future costs and claims data of these tribal clinics and reconsider options as appropriate.”⁴¹ We are concerned that CMS might soon propose further reimbursement reductions for these clinics, which will already have seen a dramatic reduction in payment under the current proposal.⁴² We urge that the Medicare outpatient hospital rates and payment methodology continue to apply to all grandfathered tribal provider-based facilities, and to any facilities that become grandfathered tribal FQHCs pursuant to the Proposed Rule. The alternative being proposed by CMS will impose a revenue loss on facilities assumed by tribes under the ISDEAA and hamper the financial feasibility of tribes assuming the responsibility to carry out IHS programs. This clearly contradicts congressional intent to encourage self-determination and self-governance by tribes through the exercise of their rights under the ISDEAA.⁴³

b. The proposed G-code system is extremely vague.

CMS proposes to establish a new set of “G-codes” that grandfathered tribal FQHCs would use to bill for Medicare visits. Each G-code would include all the services in a typical bundle of services that would be furnished per diem to a Medicare patient: one for new patients, established patients, both new and established mental health patients, and Initial Preventive Physical Examination or Annual Wellness Visit patients.⁴⁴ The tribe would determine the

⁴¹ *Id.* at 41,800.

⁴² We also emphasize that, if CMS proceeds with this proposal, any future reconsideration of the proposed rates would require additional tribal consultation.

⁴³ *See* 25 U.S.C. § 450a(b):

The Congress declares its commitment to the maintenance of the Federal Government’s unique and continuing relationship with, and responsibility to, individual Indian tribes and to the Indian people as a whole through the establishment of a meaningful Indian self-determination policy which will permit an orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in planning, conduct, and administration of those programs and services.

This commitment can scarcely be said to be fulfilled by causing a reduction in CMS reimbursement to which IHS would have been entitled merely because a tribe has taken over a portion of the program.

⁴⁴ Proposed Rule at 41,800.

services that are included in each of the five new G-codes, and the payment amount would be equal to the sum of the charges for each of the services associated with the G-code.⁴⁵

CMS gives little guidance as to how tribal health programs should go about determining the charge levels for their “G-codes,” stating only that they must be “reasonable” and “uniform for all patients, regardless of insurance status” on its July 29, 2015 All-Tribe’s Call. But the question of what constitutes a “reasonable medical charge” is highly context-specific,⁴⁶ and usually includes some combination of analyzing the relevant market for hospital services, the usual and customary rate the hospital charges, the hospital’s internal cost structure, the nature of the services provided, the average payment the provider would have accepted as full payment from third-parties, and the price an average patient would agree to pay for the service at issue.⁴⁷ This will make it difficult for tribal facilities to know whether or not they are devising charge rates that would withstand judicial scrutiny if challenged as unreasonable in whatever context. Tribes will accordingly have to devote that much more time, resources, and legal analysis to devising these G-codes in the first instance (already a burdensome process), and they will likely vary from tribe to tribe for providing identical services to the same patient population.

If CMS does ultimately move forward with the “reasonableness” standard, the TTAG requests consultation to develop uniform standards as to what constitutes reasonable charges for the purposes of grandfathered tribal FQHC payments.⁴⁸ But as noted, it would be far more preferable if CMS simply eliminated the charge-based “lesser of” G-code standard and instead authorized grandfathered tribal FQHCs to bill as if they were provider-based outpatient hospital departments.

c. Grandfathered provider-based tribal facilities should be reimbursed as provider-based during the transition to grandfathered tribal FQHC status.

In describing what a grandfathered provider-based tribal facility must do to transition to the new grandfathered FQHC status, CMS notes in the Preamble:

⁴⁵ *Id.*

⁴⁶ For example, a major tribal health program has spent the past four years in court litigating, in part, what constitutes a “reasonable medical charge” in the context of the tribal right of recovery set out in Section 206 of the Indian Health Care Improvement Act. *See generally Alaska Native Tribal Health Consortium v. Premera Blue Cross Blue Shield*, No. 3:12-cv-00065-HRH (D. Alaska).

⁴⁷ *See, e.g., Colomar v. Mercy Hosp., Inc.*, 461 F. Supp. 2d 1265, 1269 (S.D. Fla. 2006) (collecting cases applying listed factors).

⁴⁸ Because the G-codes would be identical for both Medicare and non-Medicare payors, this will help avoid disputes with both CMS and private parties concerning the reasonableness of a tribal facility’s charges.

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

To become certified as a FQHC, an eligible tribe or tribal organization must submit a Form 855A and all required accompanied documentation, including an attestation of compliance with the Medicare FQHC Conditions for Coverage at part 491, to the Jurisdiction H Medicare Administrative Contractor (A/B MAC). After reviewing the application and determining that it is complete and approvable, the MAC would forward the application with its recommendation for approval to the CMS Regional Office (RO) that has responsibility for the geographic area in which the tribal clinic is located. The RO would issue a Medicare FQHC participation agreement to the tribal FQHC, including a CMS Certification Number (CCN), and would advise the MAC of the CCN number, to facilitate the MAC's processing of FQHC claims submitted by the tribal FQHC. Payment to grandfathered tribal FQHCs would begin on the first day of the month in the first quarter of the year subsequent to receipt of a Medicare CCN.⁴⁹

But CMS has not indicated when a currently-grandfathered tribal provider-based facility will be deemed to lose that status, nor how they should bill and be paid during the interim period between submitting the Form 855A and ultimately receiving their first payment as a certified grandfathered tribal FQHC. Unless this is clarified, affected programs will not know whether they may continue to bill as provider-based entity until they are certified as an FQHC, whether they must bill as a freestanding clinic, or whether they may preemptively bill as a grandfathered tribal FQHC. In addition, CMS should assure affected programs that Medicare payments made to a grandfathered provider-based tribal facility for services it provided between the date CMS determines it lost provider-based status, and the date it begins billing as a grandfathered tribal FQHC, will not be treated as overpayments.⁵⁰

But distressingly, when CMS officials were questioned on these points on the July 28 All Tribe's Call, they responded that the agency would "work closely with the clinic and the MAC to make sure there was no lapse in payment," and suggested that such clinics "work closely with IHS to make sure there are no gaps in Medicare payments." This seems to suggest that once a clinic self-attests or is informed by CMS that it no longer satisfies grandfathered provider-based tribal status, *it may not bill Medicare at all* until the clinic receives its Medicare CCN as new grandfathered tribal FQHC.⁵¹ This would be financially devastating to tribal health programs,

⁴⁹ Proposed Rule at 41,801.

⁵⁰ CMS has not clarified when a grandfathered provider-based tribal facility will be deemed to have lost its provider-based status. In past conversations, CMS has noted that such entities may "self-attest" at their convenience that they no longer qualify for grandfathered provider-based status under CMS's reinterpretation of the rules. But this does not necessarily mean that CMS will treat the entity as provider-based until it makes such an attestation, nor has CMS clarified whether self-attestation will be required or what the consequences would be for failing to self-attest.

⁵¹ It is our understanding that qualifying as an FQHC for Medicare purposes is a burdensome and time consuming process that can often take months to finalize.

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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which increasingly rely on third party revenue, particularly Medicare and Medicaid,⁵² to account for perpetually insufficient IHS funding.⁵³ Prohibiting tribal clinics from billing Medicare at all until CMS and the MAC get around to processing their application will seriously affect the ability of tribes to remain financially viable and provide adequate patient care.

The TTAG suggests that the Final Rule authorize facilities to continue to bill as if they are provider-based during the pendency of their applications, or at the very least, allow facilities to preemptively bill as grandfathered tribal FQHCs. This would mimic the existing regulatory process for provider-based facilities, under which clinics can bill as if they were provider-based while CMS reviews a request for provider-based attestation (or, if no attestation has been filed, until such time as CMS determines that the facility is not actually provider-based).⁵⁴ We believe that this is a necessary protection for tribal clinics that might suffer devastating hardship if prohibited from billing Medicare due to CMS's reinterpretation of the law.⁵⁵

- d. FQHC requirements and the scope of covered FQHC services are unfamiliar to the affected I/T facilities and may require they restructure their operations, staffing, and clinical programs. CMS should provide extensive technical assistance and a reasonable transition period for any I/T facility that must change to FQHC status under the Proposed Rule.**

In discussions with the TTAG, CMS has explained that it believes that it can allay its concerns with violation of 42 C.F.R. § 482.12 among current grandfathered provider-based tribal facilities by instead requiring that the new grandfathered FQHCs adhere to FQHC rules,

⁵² 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. See NATIONAL INDIAN HEALTH BOARD, COMMENT TO CENTERS FOR MEDICARE AND MEDICAID SERVICES ON MEDICARE PROGRAM; MEDICARE SHARED SAVINGS PROGRAM: ACCOUNTABLE CARE ORGANIZATIONS (CMS-1345-P) 6 (June 6, 2011).

⁵³ IHS is only funded at approximately 56% of need. See NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS TO THE INDIAN HEALTH SERVICE: FISCAL YEAR 2015 BUDGET 3 (2013).

⁵⁴ See generally 42 C.F.R. § 413.65(j)-(k); UNITED STATES DEPARTMENT OF HEALTH AND SOCIAL SERVICES, PROGRAM MEMORANDUM INTERMEDIARIES TRANSMITTAL A-03-030: PROVIDER-BASED STATUS ON OR AFTER OCTOBER 1, 2002 at 2 (Apr. 18, 2003).

⁵⁵ In the event that CMS ultimately does not authorize the tribal clinics at issue to bill Medicaid during the pendency of their application, the TTAG requests additional consultation on potential streamlines to the tribal grandfathered FQHC application process to minimize any delay in the billing process.

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

not hospital rules. CMS has accordingly proposed that the grandfathered tribal FQHCs “be subject to Medicare [FQHC] regulations at part 405, subpart X, and part 491,” with the exception of the reimbursement rate provisions.⁵⁶ Because the FQHC requirements do not include integration provisions with a hospital, CMS reasons, there will be no problems moving forward.

But the TTAG is greatly concerned about tribal preparedness to make what CMS seems to believe will be a casual transition in provider status. To date, the entirety of CMS’s technical assistance concerning this transition has consisted, to our knowledge, of the July 2015 All-Tribe’s Call and its associated PowerPoint. On the call, CMS gave tribes an abbreviated comparison chart of what is or is not billable for FQHCs as compared to hospital outpatient facilities, and then directed tribes to review the applicable statutes, regulations and guidances themselves to determine how to apply for FQHC status, the differences in covered procedures between a grandfathered provider-based facility and a grandfathered tribal FQHC, the differences in billing between the two provider types, and other issues.

This lack of technical assistance will directly discourage tribes from transitioning to grandfathered FQHC status. There are numerous tribes currently operating grandfathered provider-based clinics that have never enrolled a facility as a Medicare FQHC and until now have had no reason to review any FQHC rules. Many affected entities have indicated to the TTAG that they are extremely apprehensive about what this shift will entail in terms of reimbursement rates, covered services, etc. They are also concerned about the legal and technical costs associated with understanding the scope of FQHC regulations, how they differ from hospital outpatient requirements, how this new designation will affect existing programs, and similar issues. In light of the sharp change in longstanding CMS practice, it is unacceptable that CMS place the onus on navigating the changes in the law on tribes and tribal organizations. One tribal call and a handout do not satisfy the need for information.

We request ongoing technical assistance from CMS in order to facilitate this transition. While the exact nature of this assistance should be determined in consultation with the TTAG and other tribal stakeholders, at the very least, it must include practical training for tribal billing offices and financial officers and associated legal analysis for tribal attorneys and technical advisors. CMS should also include a generous grace period in the Final Rule for making this transition: for example, allowing targeted grandfathered provider-based facilities twelve months to maintain that designation and bill Medicare accordingly before they are required to submit an application to become a grandfathered tribal FQHC. Absent this type of consultation and transition time, tribal facilities will not have the necessary information and resources to successfully adopt their new status while complying with applicable law.

⁵⁶ Proposed Rule at 41,801.

- e. **If CMS believes some affected I/T facilities would benefit by converting to grandfathered tribal FQHC status, it should make that status optional and allow interested programs a reasonable time to choose whether to continue as provider-based or convert to grandfathered tribal FQHC status.**

To date, CMS has given only a negative (and unfounded) reason why affected I/T facilities should transition to grandfathered tribal FQHC status: to avoid decertification of their associated IHS hospitals. As we have discussed above, we believe there are several potential and serious downsides for affected programs and that no program should be *required* to make the transition.

CMS has not fully explained the differences between the scope of covered FQHC services vs. provider-based services, or the differences in what qualifies as a reimbursable “visit” or “encounter” for each. But the little information CMS has provided suggests that FQHC coverage may be more comprehensive for some services, such as preventive health services. It thus seems possible that, assuming reimbursement levels were set high enough (and far higher than as currently proposed), some I/T facilities might benefit by transitioning to grandfathered tribal FQHC status and might prefer that status over continuing to be treated as provider-based. If CMS believes there may be a positive benefit for affected I/T facilities, it could allow facilities to *choose* between grandfathered tribal provider-based status and grandfathered tribal FQHC status, provide technical assistance and a reasonable time for interested programs to evaluate those alternatives and make the transition, and continue to reimburse them as provider-based in the interim.

- f. **Necessary edits to the proposed regulation text.**

In the event that CMS rejects our comments and moves forward with the new tribal grandfathered FQHC status as currently proposed, we have the following suggestions for clarifying the text and purpose of the draft regulatory language.

- i. **Clarification as to what constitutes provider-based status.**

The definition of “grandfathered tribal FQHC” at proposed 42 C.F.R. § 405.2462(d)(1) is “a FQHC [sic] that: (i) Is operated by a tribe or tribal organization under the Indian Self-Determination Education and Assistance Act (ISDEAA); (ii) Was provider-based to an IHS hospital on or before April 7, 2000; and (iii) Is not operating as a provider based department of an IHS hospital.”⁵⁷ We believe that this definition requires revision to ensure that it is not read unintentionally narrowly and in a way that would actually make the new FQHC status functionally unavailable.

CMS has made several statements to the effect that grandfathered tribal facilities “do not meet provider-based criteria,” but are instead merely “treated as provider-based” under the

⁵⁷ Proposed Rule at 41,952.

grandfather clause; that is, in CMS's view, these facilities technically are not provider-based, but are merely allowed to bill as if they were. For example, in the 2003 Provider-Based FAQ, CMS described the provider-based tribal grandfather clause as meaning that "clinics and other facilities *which do not meet provider-based criteria* but were billing as components of IHS or Tribal hospitals when the regulations were first published in final form (on April 7, 2000) may continue to *be treated as provider-based*."⁵⁸ The Preamble to the Proposed Rule similarly suggests that grandfathered provider-based tribal facilities are not actually provider-based, but are rather allowed to bill like provider-based clinics by virtue of the grandfather clause.⁵⁹ Accordingly, one could conceivably argue (albeit incorrectly) that grandfathered I/Ts are technically not "provider-based" and could not qualify for the new grandfathered FQHC status because they were not "provider-based to an IHS hospital on or before April 7, 2000."

In order to foreclose such a reading of the regulations, CMS should revise the second clause in the proposed definition along the following lines: "(ii) Was billing as if it were provider-based to an IHS hospital on or before April 7, 2000" or "(ii) Fulfilled the requirements of 42 C.F.R. § 413.65(m) on or before April 7, 2000," or "Was billing as a component of an IHS hospital on or before April 7, 2000." This will ensure that grandfathered provider-based tribal facilities qualify for the new tribal FQHC status so long as they fulfilled the applicable grandfathering requirements as of the relevant date.

ii. Clarification of the phrase "on or before April 7, 2000" for the purposes of achieving provider-based status.

As drafted, both the provider-based grandfather clause and the proposed definition of "grandfathered tribal FQHC" include as a requirement that the facility have been billing as an outpatient hospital department "on or before April 7, 2000." CMS has interpreted this language as requiring that the facility have actually billed that way "on" April 7, 2000, specifically.

But this interpretation reads the "or before" language out of the regulation entirely. There are multiple tribal facilities that would have been considered provider-based "before" April 7, 2000, but because they were given incorrect instructions by the federal government, instead assumed FQHC status prior to April 7, 2000.⁶⁰ Under CMS's interpretation, even though these facilities were provider-based "before" the cutoff date, which by the plain language of the regulation is permissible for achieving grandfathered provider-based tribal status, they are ineligible for such status because they were not provider-based "on" that specific date.

This interpretation fails for two reasons. First, it is a "cardinal principle of . . .

⁵⁸ PROVIDER-BASED FAQ at 1 (emphasis added).

⁵⁹ Proposed Rule at 41,799 ("The Medicare outpatient rate is only applicable for those IHS or tribal facilities that meet the definition of a provider-based department as described at § 413.65(a), or a 'grandfathered' facility as described at § 413.65(m).").

⁶⁰ See Section II(5)(b), below.

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

construction” that when interpreting a statute or regulation, “no clause, sentence, or word shall be superfluous, void, or insignificant.”⁶¹ Rejecting eligibility for grandfathered provider-based tribal status for tribal clinics that satisfied the grandfather clause “before” April 7, 2000 renders the “or before” clause a virtual nullity, and is unsupported. Second, tribes assume operations over grandfathered provider-based clinics under the auspices of the ISDEAA. The ISDEAA was specifically designed to “incorporate[] the longstanding canon of statutory interpretation that laws enacted for the benefit of Indians are to be liberally construed in their favor.”⁶² This pro-tribal canon of interpretation is reflected in the numerous ISDEAA and regulatory provisions requiring that the law be liberally construed “for the benefit of Indian tribes” and holding that “any ambiguities herein [must] be construed in favor of the Indian tribe.”⁶³ Courts and agencies have repeatedly noted that “[t]hese provisions show that Congress intended the ISDA to be implemented in a manner favoring flexibility in funding agreements” and other ISDEAA activities.⁶⁴ Excluding the “or before” clause from the regulation is a narrow, anti-tribal interpretation of the law as applied to an ISDEAA program that violates statutorily

⁶¹ *Duncan v. Walker*, 533 U.S. 167, 174 (2001) (citations and internal quotations omitted).

⁶² S. REP. NO. 103-374, at 11 (1994); *See also* S. REP. NO. 102-392, at 43 (1992), *reprinted in* 1992 U.S.C.C.A.N. 3943, 3985 (“The Committee intends [the ISDA] to be interpreted by the Department in a way that facilitates the inclusion of a program or activity in the project and effectuates the full implementation of the project.”).

⁶³ 25 C.F.R. § 900.3(11); *accord* 25 U.S.C. § 458aaa-11(a) (requiring HHS to “interpret all Federal laws, Executive orders, and regulations in a manner that will facilitate . . . the achievement of tribal health goals and objectives”); *id.* at § 458aaa-11(f) (noting that “each provision of a compact or funding agreement shall be liberally construed for the benefit of the Indian tribe participating in self-governance and any ambiguity shall be resolved in favor of the Indian tribe”); 25 U.S.C. § 458cc (requiring HHS to interpret “each Federal law and regulation” in a manner that will facilitate the implementation of ISDA funding agreements and “the inclusion of programs, services, functions, and activities” in such agreements); 42 C.F.R. § 900.3(a)(8) (same).

⁶⁴ *Maniilaq Ass’n v. Burwell*, 72 F. Supp. 3d 227, 233 (D.D.C. 2014); *accord Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2193 (2012) (noting that the “ISDA is construed in favor of tribes”); *Ramah Navajo Chapter v. Salazar*, 644 F.3d 1054, 1057 (10th Cir. 2011) (applying canon in favor of tribe in ISDA dispute); *Ramah Navajo Chapter v. Lujan*, 112 F.3d 1455, 1462 (10th Cir. 1997) (holding that “if the [ISDEAA] can reasonably be construed as the Tribe would have it construed, it must be construed that way”); *Bristol Bay Area Health Corp. v. United States*, 110 Fed. Cl. 251, 259 (2013) (noting that “any ambiguities in the contracts, as well as the ISDA, must be resolved in favor of Bristol Bay”); *see also Appeal of Citizen Potawatomi Nation of Oklahoma*, IBCA No. 4522/04, 05-1 B.C.A. (CCH) ¶ 32919 (Mar. 22, 2005) (“Treaties and federal Indian statutes are interpreted in favor of retained tribal self-government and property rights as against competing claims under state law. Doubts or ambiguities in treaties or statutes are resolved in the Indians’ favor. Federal Indian laws are interpreted liberally toward carrying out their protective purposes.”).

enacted and judicially upheld canons of construction.

CMS should clarify that facilities which satisfied the provider-based tribal grandfather clause “before” the cutoff date may still qualify for grandfathered tribal FQHC status even if they were not designated as provider-based on the cutoff date itself.

6. Additional consultation is required on several issues pertaining to the Proposed Rule.

a. CMS did not adequately consult with tribes prior to releasing the Proposed Rule.

The Proposed Rule represents a fundamental shift in CMS policy: to our knowledge, this is the first time that CMS has ever taken the position that both a hospital and its associated grandfathered provider-based tribal clinic must satisfy the administrative integration COPs. This new interpretation directly counters published, longstanding CMS guidance on the topic, such as the 2003 FAQ, as well as decades of tribal practice.

CMS was demonstrably aware that this is a critical issue for tribes, as agency officials attended the TTAG’s February 2015 meeting specifically to discuss the matter. The CMS representatives subsequently requested a written explanation of the legal authority under which tribal facilities could retain provider-based status, and hospitals retain their Medicare certification, despite the failure to comply with the administrative integration COPs. While the TTAG drafted the analysis, which it had assumed CMS would review and discuss prior to taking any formal regulatory action, CMS was simultaneously drafting the Proposed Rule. CMS responded to its receipt of the TTAG memorandum by forwarding us the Proposed Rule and noting that they were using the Proposed Rule to address the TTAG’s concerns. But as set out above, the proposal instead offers an entirely new course of action that raises a host of problems in its own right and is unnecessary under existing law.

We have previously noted that it is far more difficult for tribal advocates to affect changes in proposed rules once they have been released for public comment, as compared to when an issue is examined on a government-to-government basis and tribal input is considered prior to CMS issuing a public statement or document. We implore CMS to consult with the TTAG and other tribal stakeholders in the future before it issues drastic proposed changes to regulations affecting tribes.

b. Consultation is needed to correct erroneous provider-based determinations.

In addition to the need for general consultation on the Proposed Rule and provider-based status generally, the TTAG requests CMS consultation concerning various federal agency errors that have greatly impeded tribal eligibility for grandfathered provider-based status in

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

Oklahoma.⁶⁵ Prior to the implementation of self-governance under the ISDEAA, IHS administered the Shawnee Service Unit (SSU) for the benefit of five local Tribes: the Nation, Kickapoo, Sac & Fox, Iowa, and Absentee Shawnee. The SSU clinic had provider-based status with Carl Albert Indian Hospital in Ada, Oklahoma, an IHS-owned hospital whose operations have since been assumed by the Chickasaw Nation (the Nation).⁶⁶

In federal fiscal year 1998, the Nation entered into an ISDEAA compact with IHS to manage all health care programs that IHS had previously operated on behalf of the Nation. This included a share of the IHS Shawnee Health Center, and a share of the inpatient care provided by Carl Albert. But without explanation, IHS refused to continue processing Medicare claims from the Shawnee Health Center (now known as the Ambulatory Health Center) as a provider-based facility in association with Carl Albert. And at the Nation's subsequent self-governance negotiation, IHS informed that Nation that it only had two choices with regard to the Health Center: the Nation could either enroll the Health Center in Medicare as an FQHC and bill at an all-inclusive rate under a cost report, or else organize as a private health clinic and bill fee for service. This was presented as an either/or proposition, and the Nation was not made aware of the possibility of the Health Center being treated as a provider-based entity.

The Nation subsequently enrolled the Health Center as an FQHC, a status it retained as of the April 7, 2000 "deadline" for qualifying as a grandfathered provider-based tribal facility. As a result of the Nation's FQHC designation, IHS compounded its initial error by failing to include the Health Center on the list of provider-based clinics that the Oklahoma City Area IHS submitted to CMS, thus giving CMS no reason to inquire into the change in the Health Center's billing status or otherwise questioning its accuracy.

Since realizing the agency's error in 2000 (only months after transitioning to FQHC status), the Nation has continually attempted to rectify IHS's mistake and qualify as grandfathered provider-based tribal facilities.⁶⁷ They (correctly) note that, as discussed above, the applicable regulation requires the provider-based relationship to have been established "on *or before* April 7, 2000" (emphasis added), and that the "or before" clause should be interpreted to encompass the relationships between the clinics and Carl Albert that existed prior to that date but were later terminated. Agreeing with the tribes, the Oklahoma Area IHS Director sent a letter to the Regional Director in 2005 acknowledging that the clinics at issue "are tied together clinically, administratively, and fiscally [with Carl Albert] and . . . should have been on the original grandfather list that was published April 7, 2000," that the "inadvertent omission of

⁶⁵ This issue arose during the July 2015 TTAG face-to-face meeting, at which time CMS staff requested that the TTAG include the issue in its ultimate provider-based comments. While our comments focus on Oklahoma given its history of advocacy on this matter, they equally apply to any other facilities or IHS Areas facing similar issues.

⁶⁶ This facility is now known as the Chickasaw Nation Medical Center.

⁶⁷ We understand that IHS and CMS may have made similar errors with regard to other Oklahoma tribes, and perhaps those in other parts of the country.

[these facilities] by this office should in no way exclude them from being formally added to the list of provider based facilities as hospital based under the CMS classification,” and requesting assistance in aiding the clinics in achieving that status.⁶⁸ However, in 2007 the Acting CMS Administrator rejected the tribes’ request.⁶⁹

The Nation could (and would) have been billing as provider-based since 2000 but for IHS’s misleading directions and CMS’s refusal to correct these mistakes. This has led to over a decade of decreased revenues and the inability of the Nation to reinvest third party income in additional health services for their communities. In order to fulfill the federal government’s trust responsibility and rectify the combined IHS and CMS errors that led to this situation, the TTAG’s requested consultation on provider-based issues must include discussion of a strategy through which to deem any such affected clinic as a grandfathered provider-based tribal facility.

III. Conclusion.

For almost twenty years, CMS recognized that the provider-based tribal grandfather clause exempts qualifying facilities from compliance with the management integration requirements of both (1) the provider-based COPs and (2) Part 482. The clause does not make sense when interpreted in any other manner, and there is no reason CMS should require a transition away from grandfathered provider-based status at all.

In addition, the TTAG is very concerned with numerous aspects of the Proposed Rule. Specifically, we believe that the administrative transition to the grandfathered tribal FQHC status is unclear and, as drafted, suggests that tribal clinics will lose their Medicare billing privileges in the interim. We also believe that the proposed payment rates would dramatically lower payments to tribes and be difficult to implement, and that the proposed definition of “grandfathered tribal FQHC” requires revision. In addition, the added confusion paired with lower payment rates will discourage tribes from exercising their right of self-governance by assuming operations of clinics currently enrolled as grandfathered provider-based tribal facilities.

We appreciate the opportunity to continue our dialogue with CMS on these important matters. In order to ensure adequate consultation on these and related issues, prior to CMS issuing a Final Rule, the TTAG requests the formation of a Tribal-CMS provider-based status workgroup, as well as nationwide tribal consultation concerning CMS’s interpretation of the Proposed Rule and applicable requirements. It is extremely important that tribes be given an opportunity to review and comment on what would be a sharp change in CMS policy with potentially serious consequences for IHS and tribes that provide clinical services in conjunction with a hospital. This consultation must go beyond merely providing comments on a Proposed Rule.

⁶⁸ Letter from John Daugherty, Jr., Area Director, Oklahoma City Area IHS, to Linda Penn, Regional Director, HHS Region VI (Nov. 15, 2005).

⁶⁹ Letter from Leslie V. Norwalk, Acting Director, Centers for Medicare and Medicaid Services, to The Honorable John A. Barrett, Chairman, Citizen Potawatomi Nation (Apr. 17, 2007).

Tribal Technical Advisory Group

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Please do not hesitate to contact us with any comments or further questions, or if we can provide you with any additional information.

Sincerely,



W. Ron Allen,
Tribal Chairman and CEO, Jamestown S'Klallam Tribe
Chairman, Tribal Technical Advisory Group

Cc:

Kitty Marx, Director, CMS Division of Tribal Affairs