Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
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Submitted electronically though www.regulations.gov

June 25, 2018

Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8011
Baltimore, MD 21244-1850

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment Systems and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of claims (CMS-1694-P)

Dear Centers for Medicare & Medicaid Services:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), I write to provide comment on the notice of proposed rulemaking regarding the Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates, et al.

The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care programs funded (in whole or part) by CMS. In particular, TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/AN) under these federal health care programs, including through providers operating under the health programs of the Indian Health Service (IHS), Tribes, Tribal organizations, and Urban Indian organizations (I/T/Us or Indian health care providers). We appreciate the opportunity to provide comment on this proposed rule.

Hospital Acquired Conditions Measures

We support many of the provisions of the rule including the un-duplication with Medicare value based purchasing, however we are concerned about the potential impact of proposed alternative scoring methodologies for calculating total Hospital Acquired Conditions scores. We have heard of instances where small rural Tribal hospitals domain score was low, because they had less than 1.0 predicted infections for all other measures. This single measure resulted in 85 percent of their HAC score and resulted in a penalty for two years. In the rule, CMS proposes to either, remove the domains and weight all measures equally, or to limit the maximum Domain

2 weight from 85% to 60% when only one Domain 2 measure is scored. We appreciate that CMS is taking the needs of rural hospitals into account with this move, however it is not enough. Even with the proposed changes, small rural Tribal hospitals would still be penalized. When volumes are low, shifting the weighting to only where there are reported incidents only serves to artificially weight and enhance them, rather than giving the hospital its due credit for having zero incidents in other identified measures, either within the domains or among the two domains. Finally, the use of 'expected' events is contrary to the objectives of the program for small and rural hospitals. If a low volume hospital has no events in previous years, the expected rate becomes very low. One incident will then result in a very detrimental result for the hospital.

We continue to encourage the review of the PSI-90 measure as a whole. PSI-90 is a deeply flawed measure, and we question its presence in the HAC or any payment reform program. We request that CMS transition the PSI measure out in favor of something more meaningful and effective. The data does not provide Tribal hospitals usable information to improve performance.

In summary, we would recommend that CMS establish an exclusion for low volume hospitals, or further refine the methodology to achieve the desired result and accurately depict performance of rural hospitals.

Graduate Medical Education

Currently, Indian Health Service and Tribal hospitals are not eligible for Medicare funding for Graduate Medical Education (GME) programs. The Veterans Administration was deemed eligible in recent years, however. GME is an excellent opportunity to provide Indian Health and Tribal health systems with a powerful recruitment and retention tool, which is woefully needed in Indian Country. Further, GME also significantly enhances the quality of care through its teaching staff, which is also a challenge in the Indian health system. We strongly recommend that Indian Health Service and Tribal Hospitals should be made eligible to receive Medicare funding for residency programs.

Requirements for Hospitals to Make Public List of Standard Charges

The proposed rule contains a section for requirements for hospitals to make public a list of their standard charges via the internet. This section of the proposed rule revisits a reminder contained in the FY 2015 IPPS Proposed Rule and ultimately the initial calls for transparency in the Affordable Care Act (specifically, 2718(e) of the Public Health Service Act). That language required hospitals to "either make public a list of their standard charges (whether that be the charge master itself or in another form of their choice) or their policies for allowing the public to view a list of those charges in response to an inquiry." The proposed rule discusses CMS concerns that challenges continue to exist for patients due to insufficient price transparency. CMS explains that such challenges include patients being surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and patients being surprised by facility fees and physician fees for emergency room visits. To address this, CMS is

considering ways to improve the accessibility and usability of the charge information that hospitals are required to disclose under section 2718(e) of the Public Health Service Act.

Effective January 1, 2019, CMS will update its guidelines to require hospitals to make available a list of their current standard charges via the internet in a machine readable format and to update this information at least annually, or more often as appropriate. We compliment CMS to continue the national dialogue on price transparency as many providers struggle with how to effectively improve price transparency with consumers. Many state legislatures and local municipalities have also taken up the concerns about price transparency with consumers. However it is critically important to note that beneficiaries of the Indian health system do not have to pay for care that they receive from IHS, Tribal, and urban Indian health programs. Since IHS and Tribal hospitals do not charge its patients for services it would be extremely difficult for Indian health providers to develop fee for service schedules that private hospitals maintain in the course of their day to day operations.

Therefore it would not be appropriate to require Indian health providers to comply with the price transparency requirements discussed above. It would also be very confusing to beneficiaries of the Indian health system to see such information since our patients are accustomed to not pay for services when they go to an IHS or Tribally-operated hospital. We recommend that the proposed rule exempt Indian health providers from any of the price transparency requirements included at section X.

We thank you for the opportunity to provide comments and recommendations and look forward to further engagement.

Sincerely,

W. Ron Allen

Ron Allen, Chair
Tribal Technical Advisory Group

Cc: Kitty Marx, Director, CMS Division of Tribal Affairs