

# Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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*Submitted via FederalRegister.gov*

July 10, 2020

The Honorable Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8013  
Baltimore, MD 21244-1850

**Re: Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1735-P)**

Dear Administrator Verma:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to provide a response to the Centers for Medicare and Medicaid Services (CMS) proposed rule, “Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 rates.” The TTAG greatly appreciates CMS’s decision to exclude Tribes from the price transparency requirement in 2019.<sup>1</sup> Since Indian Health Service (IHS) and Tribal hospitals do not serve the public, their rates do not need to be subject to negotiation.

However, the TTAG is concerned that the proposed rule would change CMS’s methodology for calculating uncompensated care payments, resulting in lower Disproportionate Share Hospital (DSH) payments for the vast majority of IHS and Tribal hospitals.

The TTAG looks forward to working with CMS as it finalizes changes to the IPPS program for FY 2021.

**Background**

United States owes a special duty of care to Tribal Nations, which animates and shapes every aspect of the federal government’s trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government’s unique responsibilities to Tribal Nations has been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and

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<sup>1</sup> <https://www.hhs.gov/sites/default/files/cms-1717-f2.pdf> See pg. 34, section 2: “Special Requirements That Apply to Certain Hospitals”

regulations.<sup>2</sup> In 1977, the Senate report of the American Indian Policy Review Commission stated that, “[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people.” This trust responsibility is highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

Importantly, the Federal Government has a unique legal and political government-to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals’ relationship to Tribal governments.<sup>3</sup>

The trust responsibility establishes a clear relationship between the Tribes and the federal government.<sup>4</sup> The existence of this truly unique obligation supplies the legal justification and foundation for distinct health policy and regulatory making when dealing with American Indians and Alaska Natives (AI/ANs) and the Indian health system that provides their care. The federal government is responsible for ensuring the health of the Indian health system and its ability to provide health care to AI/ANs. Any action that impairs that ability is a violation of the trust responsibility.

#### *The Uniqueness of the Indian Health System Must be Considered*

As CMS knows, the Indian Health System is unique. It does not fit well into the framework that CMS is proposing to adjust for uncompensated care payments. The TTAG believes that CMS’s proposed changes to the uncompensated care methodology will adversely impact most providers that qualify for Medicare DSH payment in the Indian Health System.

The IHS and Tribal (I/T) system has been severely and chronically underfunded for some time. Congress authorized the I/T system to bill Medicare in an effort to increase federal funding to the I/T system and to bring it into compliance with Medicare Conditions of Participation. While the I/T system has long participated in the Medicare program, it still does not get the benefit of full Medicare reimbursement for treating Medicare enrolled individuals. This disparity is because I/T providers, including hospitals, do not charge AI/AN patients copays.<sup>5</sup> Patients receive treatment regardless of health insurance status. As a result, for every Medicare patient seen in the I/T system, the facility absorbs the 20 percent copay.

Congress has recognized the need to preserve federal resources for the I/T system and ensure that resources from other federal programs supplement rather than replace IHS funding. For example,

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<sup>2</sup> The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. See Seminole Nation v. United States, 316 U.S. 286 (1942), United States v. Mitchell, 463 U.S. 206, 225 (1983), and United States v. Navajo Nation, 537 U.S. 488 (2003).

<sup>3</sup> Introduction, “Cross-Agency Collaborations”, <https://www.hhs.gov/about/strategic-plan/introduction/index.html>

<sup>4</sup> In Worcester v. Georgia, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third party actors.

<sup>5</sup> The IHS is prohibited from charging any Indian for services, including co-pays, 25. U.S.C. §1680r(b), and while tribally operated programs may elect to do so, 25. U.S.C. §1680r(a), few have chosen to do so due to their members’ inability to pay. We are unaware of any Tribally operated program that collects Medicare co-pays from the IHS eligible Medicare beneficiaries they serve.

as part of the Patient Protection and Affordable Care Act (ACA), Congress included a provision that makes Indian health programs the payer of last resort for persons eligible for services.<sup>6</sup> This means that other federal programs like Medicare, Medicaid, and Veterans Affairs (VA) must pay first before IHS resources are used, and demonstrates the Congress's commitment that federal resources for tribes be maximized. It demonstrates the federal government's recognition of the unique charge the federal government has with regard to Indian country and provides an example of how it has appropriately tailored law and policy to advance the trust responsibility. We urge CMS to follow Congress' example, and implement its proposed changes to its methodology for calculating uncompensated care payments in a manner that maximizes access to federal resources through the Medicare program for the I/T system rather than unfairly penalize them and reduce DSH payments. As discussed below, the proposed changes to the uncompensated care methodology would result in significant cuts to DSH payments to I/T hospital providers. Indian health facilities have significant amounts of uncompensated care, such as co-pays and deductibles for Medicare and private insurance, and charity care that far exceeds the federal appropriated funding for the number of native patients served. However, as explained below, the uncompensated care formula in use by CMS does not provide a pathway for I/T hospitals to report this uncompensated care in a manner that is similar to other hospital systems.

#### *Changes to the DSH Methodology Must Do no Harm to the Indian Health System*

Section 3133 of the ACA modified the Medicare Disproportionate Share Hospitals (DSH) payment methodology beginning in FY 2014. The former DSH methodology provided hospitals a DSH payment adjustment under a statutory formula that considered the Medicare utilization of beneficiaries who received Supplemental Security Income (SSI) benefits. The ACA modified the method for computing Medicare DSH adjustments (for discharges occurring on or after October 1, 2013) by paying hospitals 25% of the amount determined under the traditional method; and the remaining 75 percent is now paid to hospitals based on its share of uncompensated care costs relative to all Medicare DSH-eligible hospitals.<sup>7</sup> Hospitals use the Medicare Cost Report Worksheet S-10 (CMS-Form-2552-10) to report uncompensated care to CMS. Prior to the ACA, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) also made a number of changes to the DSH program including the imposition of a 12% cap on the DSH payment adjustment for certain hospitals whose Disproportionate Patient Percentage (DPP) exceeds 15 percent.<sup>8</sup>

For IHS and Tribal hospitals, CMS adopted the policy of substituting data regarding FY 2013 low-income insured days for the Worksheet S-10 data when determining uncompensated care costs. CMS reasoned that the use of data from Worksheet S-10 to calculate the uncompensated care amount for IHS and Tribal hospitals would jeopardize these hospitals' uncompensated care

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<sup>6</sup> 25 U.S.C. § 1623(b).

<sup>7</sup> "Acute Care Hospital Inpatient Prospective Payment System", <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctshst.pdf>, accessed 7/7/2020.

<sup>8</sup> "Centers for Medicare & Medicaid Services, Medicare Learning Network (2017). Medicare Disproportionate Share Hospital (ICN 006741)." Fact Sheet. [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Disproportionate\\_Share\\_Hospital.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Disproportionate_Share_Hospital.pdf), accessed 5/2/2019.

payments due to their unique funding structure. The proposed rule explains that CMS is proposing to continue to use the low-income insured days as a proxy to calculate Factor 3 for IHS and Tribal hospitals in FY 2021, and beginning in FY 2022 will restructure Medicare DSH payments and uncompensated care payments to IHS and Tribal hospitals.

IHS and Tribal hospitals do not complete the Worksheet S-10 because the administrative burden and its associated data are not easily accessible without undue financial cost to complete the form. Because of this, CMS has used a proxy measure for the I/T/U to calculate uncompensated care costs. Based on IHS' analysis of 17 IHS-operated facilities and 11 Tribal facilities, uncompensated reimbursements for IHS and Tribal hospitals under 100 beds amounted to nearly \$12.8 million in 2019<sup>9</sup>. Applying CMS's proposed change so that Medicare DSH payment methodology mirrors the calculation of the Medicare DSH payment under the Social Security Act § 1886(d)(5)(F), IHS projected the reimbursements for the same facilities in 2020 would be \$7.5 million less—a reduction of 58% in DSH payments. It is important to note that two IHS and Tribal facilities have more than 100 beds, and would not be subject to the 12 percent DSH cap. Without the proxy measure, the estimated reimbursement for these two facilities in FY 2020 is \$15 million, which is \$6.9 million greater than their combined reimbursement in FY 2019. To summarize, the 26 smaller facilities stand to collectively lose \$7.5 million in DSH reimbursements, while two larger facilities stand to gain \$6.9 million if CMS's proposed methodology is approved.

Overall, the TTAG finds the shift in reimbursements troubling to the system as a whole. While TTAG appreciates that the two larger facilities would benefit due to the absence of the 12% cap, we would like to see that change implemented for all Indian health system facilities. We emphasize the damage the proposed change would have on the majority of the facilities. Smaller facilities already have limited capacity and losing reimbursement funding could threaten their long-term viability.

### **Recommendations:**

#### I. TTAG recommends CMS provide additional time to formulate alternatives

One of the goals of the proposed rule and agency action is to promote equity across the system. Tribes support this objective, and we believe that equity can only be achieved by implementing a system that recognizes the true levels of uncompensated care experienced by the I/T hospital systems. We are aware of similarly situated entities that have been authorized to use alternative methods to document charity care, and these examples may provide a framework that could be used by the I/T hospitals. If these examples are not instructive, several other potential alternatives exist to provide a pathway for I/T hospitals to report uncompensated care. While we are confident a solution may be found, we believe that crafting a fair, equitable and durable solution will require additional time. Specifically, and at a minimum, we would request an additional year to provide comments on the proposed rule, and once published, we would request a three year implementation timeline to phase in the newly developed methodology, as has been granted to non-Indian health

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<sup>9</sup> See the enclosure: IHS "Analysis of Proposed Rule: DSH and UCC Payments Based on 2019 Data"

facilities in the past. As such, we ask for an extension of the proxy method for the time being, and a graduated implementation after the agency reaches a decision.

II. Completing Worksheet S-10 is administratively burdensome and CMS needs to provide Tribal guidance on what can be claimed as UCC, charity care, Medicare bad debt

As discussed above, the I/T system should be authorized to document the full extent of its uncompensated and charity care, which the S-10 does not allow. In order to effectively complete Worksheet S-10, CMS needs to work the TTAG, IHS and those Tribal programs that complete cost report to develop guidance on completing Worksheet S-10. In addition, the I/T health information system is not presently capable of collecting the data needed for S-10 report at many locations. System and process changes would need to be implemented for both Indian Health and Tribal facilities to comply and begin filing the S-10 worksheet. While IHS recently received new funding to update its IT system, it will likely be years before that system is fully operational and capable of generating the information required by the S-10 form. We are concerned about the administrative and financial burden that this would create for a system that is already underfunded and under resourced.

III. Alleviate the Impact of the Twelve Percent Cap on IHS Providers

It is the imposition of the 12% cap on Medicare DSH payments that unintentionally jeopardizes IHS and tribal hospitals who serve many low-income Medicare patients with significantly lower health status and are costlier to treat on average than other Medicare patients with the same diagnosis. While the Medicare DSH cap may only affect a relatively small number of urban and rural hospitals, it effects 93% of the IHS and tribal hospitals.<sup>10</sup> As mentioned in the previous section, only two of the 28 facilities IHS studied have more than 100 beds. One facility is operated by IHS, and another is Tribal.

TTAG recommends that CMS mitigate the impact of the 12 percent cap for all I/T facilities. All I/T facilities are not-for-profit entities which through funds appropriated by the Congress, advance the trust responsibility. All Medicare reimbursements to I/T providers are required by Section 401 of the Indian Health Care Improvement Act (IHCIA) to be reinvested in the health program in some way.<sup>11</sup>

Mitigating the 12% cap on I/T facilities would advance the intent of the Congress to maximize federal resources for the Indian health system. To the extent that the 12% cap cannot be waived without a statutory fix, we urge CMS to adopt changes to its methodology for calculating uncompensated and charity care that is specific to the Indian health system as it has for other uniquely situated providers in a manner that makes up for the disproportionate impact the 12% cap has on Indian health care providers.

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<sup>10</sup> The Indian Health Service reports that 28 hospitals complete Medicare cost reports.

<sup>11</sup> 25 U.S.C. § 1641.

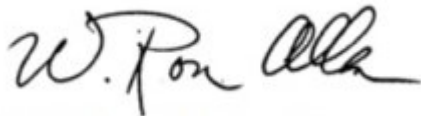
We recommend that CMS mitigate the effect of the 12% cap by providing I/T programs an additional DSH payment to off set the financial impact that the cap will have on Tribal programs.

**Conclusion**

The proposed changes to the uncompensated care payment methodology will harm the majority of facilities in the Indian Health system, because it does not accurately calculate uncompensated and charity care provided by Indian health care providers. We request an extension of the current proxy calculation until further consultation with Tribes occurs and the new rule is published, and at that time, we would request that a three-year phase-in is allowed for our facilities. We also request that CMS work to mitigate the impact that the 12% cap on Medicare DSH payment has on the I/T system.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is written in a cursive style with a large initial "W" and a long, sweeping underline.

W. Ron Allen

Chair, Tribal Technical Advisory Group