

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

June 28, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1752-P,
P.O. Box 8013
Baltimore, MD 21244-1850

Re: Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1752-P)

Dear Administrator Brooks-LaSure:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to respond 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 2019.¹ 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 remains 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. We voiced these concerns in our comment on the FY 2021 IPPS rule and were dismayed to see that CMS has yet to address our concerns.

The TTAG also notes that CMS is using this proposed rule as a mechanism to move to suppress specific measures of Hospital Acquired Conditions (HAC) for the third and fourth quarters of FY 2020. We wish to reiterate our long-standing ask that Indian health care providers be exempt from HAC calculations. We believe that CMS’s decision to alter the formula in this instance indicates an ability to alter it in other cases. As we have stated before, the HAC unfairly disadvantages Indian health care providers and provides a distorted view of the quality of care provided. We would like to see an exemption for Indian health care providers from this measure.

The TTAG looks forward to working with CMS as it finalizes changes to the IPPS program for FY 2022.

Background

The 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 obligations to Tribal Nations

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

has been repeatedly reaffirmed by the Supreme Court, legislation, executive orders and regulations.² 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.³

The trust responsibility establishes a clear relationship between the Tribes and the federal government.⁴ The federal government is responsible for ensuring the health of the Indian health system and its ability to provide health care to American Indians and Alaska Natives (AI/ANs). Any action that impairs that ability is a violation of the trust responsibility.

CMS Must Consider the Unique Nature of the Indian Health System

As CMS knows, the Indian Health System is unique. It does not fit well into the framework that CMS uses for uncompensated care payments. The TTAG believes that CMS’s uncompensated care methodology is ill-fitted for the Indian Health System.

The IHS and Tribal (I/T) systems have been severely and chronically underfunded for many years. Congress authorized the I/T system to bill Medicare to increase federal funding to the I/T system and 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 benefit from full Medicare reimbursement for treating Medicare-enrolled individuals. This disparity is because I/T providers, including hospitals, do not charge AI/AN patient’s copays.⁵ 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 other federal programs supplement resources rather than replace IHS funding. For example, 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.⁶ As a result,

² 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).

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

⁴ 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.

⁵ 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.

⁶ 25 U.S.C. § 1623(b).

federal programs like Medicare, Medicaid, and Veterans Affairs (VA) must pay before IHS can use their resources. Moreover, this intent demonstrates Congress's commitment to maximizing federal resources for Tribes. It demonstrates the federal government's recognition of its unique obligation 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, CMS's uncompensated care methodology would significantly cut 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 federally 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

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 2022. We support this continued use of FY 2013 low-income days as a substitute for Worksheet S-10.

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 their share of uncompensated care costs relative to all Medicare DSH-eligible hospitals.⁷

Hospitals use the Medicare Cost Report Worksheet S-10 (CMS-Form-2552-10) to report uncompensated care to CMS. Additionally, 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.⁸

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

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

⁸ "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, accessed 5/2/2019.

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amount for IHS and Tribal hospitals would jeopardize these hospitals' uncompensated care payments due to their unique funding structure.

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. In recognition of IHS and Tribal hospitals' unique funding structure, CMS has used a proxy measure for the I/T/U to calculate uncompensated care costs.

We urge CMS to continue using this proxy measure rather than Worksheet S-10 for IHS and Tribal hospitals in future years. 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 2019⁹. Applying the new DSH methodology so that Medicare DSH payment methodology mirrored 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 have been \$7.5 million less—a reduction of 58% in DSH payments. It is important to note that two IHS and Tribal facilities had more than 100 beds, and would not have been subject to the 12 percent DSH cap. Without the proxy measure, the estimated reimbursement for these two facilities in FY 2020 was \$15 million, which was \$6.9 million greater than their combined reimbursement in FY 2019. To summarize, the 26 smaller facilities stood to collectively lose \$7.5 million in DSH reimbursements, while two larger facilities stood to gain \$6.9 million.

Hospital Acquired Conditions

The Hospital Acquired Conditions formula unfairly discriminates against I/T hospitals. I/T hospitals have a low predicted rate of infections resulting from historically low rates. A difference between the predicted rate and the actual rate can skew an I/T hospital's score. Even a single future case results in worse than predicted, which has a skewing effect on a hospital's score. Another problem is that AI/ANs, on average, have poorer health outcomes than the general population, which result in longer hospital stays, which increases the risk of HACs. No adjustment accounts for vulnerable patient populations. Finally, we want to point out that our concern with the formula is not based primarily on the reduction in payment, but rather on being called out – incorrectly – as one of the worst-performing hospitals for HACs in the United States. This undermines trust and faith in the only health system many AI/ANs have, resulting in patients deferring care which can cause greater harm than the HAC program is designed to address.

Graduate Medical Education

The TTAG also notes that this rule will be used as the vehicle for implementing the Consolidated Appropriations Act of 2021's creation of 1,000 new Graduate Medical Education (GME) positions over the next five years. As noted in the proposed rule, the positions will be distributed according to four statutorily defined categories.¹⁰ While we agree that Indian health providers would likely

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

¹⁰ As stated on pg. 25503, "(1) Hospitals located in rural areas or that are treated as being located in a rural area (pursuant to sections 1886(d)(2)(D) and 1886(d)(8)(E) of the Act); (2) hospitals in which the reference resident level of the hospital is greater than the otherwise applicable resident limit; (3) hospitals in states with new medical schools

be eligible under multiple categories, we also know that there is no guarantee that Indian health care providers will receive any of these new GME spots. We would like to see a Tribal set-aside for Indian health care providers.

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 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. Use of the S-10 is not currently possible by the I/T System

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 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. The IHS does not currently have an interoperable Electronic Health Record (EHR) system and as a result I/T system cannot start using the S-10. While IHS recently received new funding to update its I/T system, it will likely be years before that system is fully operational and capable of generating the information required by the S-10 form.

TTAG fully supports continued use of FY 2013 low-income insured days to calculate Factor 3 for IHS and Tribal hospitals. We urge CMS to work with Tribes to develop a methodology for calculating uncompensated and charity care that accurately captures uncompensated and charity care provided by Indian health care providers and that is used as an alternative to Worksheet S-10.

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

or additional locations and branches of existing medical schools; and (4) hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs). Section 1886(h)(9)(F)(ii) of the Act defines a qualifying hospital as a hospital in one of these four categories.”

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.¹¹ 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. If a facility has 100 or more beds, it is not subject to a 12 percent payment cap.

We are aware that the cap is statutorily imposed by the MMA and that CMS cannot act unilaterally to change it. However, we believe that CMS should work with Congress to remove the 12 percent cap for all I/T facilities. All I/T facilities are not-for-profit entities which use funds appropriated by the Congress to advance the trust responsibility. All Medicare reimbursements to I/T providers are required by Section 401 of the Indian Health Care Improvement Act (IHCA) to be reinvested in the health program in some way.¹²

Removing the 12% cap on all 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.

IV. CMS must exempt Indian health care providers from HAC calculations.

For the reasons mentioned above, CMS must exempt Indian health care providers from HAC calculations. We do not believe that this system presents an accurate picture of the quality of care provided at Indian health care facilities. Our hospitals are often small, and as such, a small number of incidences can have an inaccurate skewing effect on the data. We believe that the inaccurate picture created by the current HAC formula paints a negative picture of the Indian health care system, undermining confidence in the quality of care provided. CMS must provide an exemption to the HAC calculation for Indian health care facilities.

V. CMS must create a tribal set-aside for the newly allocated Graduate Medical Education positions and require service to Tribal communities

TTAG believes that CMS should exercise its discretion and require a Tribal set-aside in GME slots and require service to Tribal communities. The development of this set-aside should be done in consultation with Tribal nations. Additionally, CMS should work to remove administrative impediments to participation in GME funding by Indian operated hospitals. As mentioned above, the Indian health care system is chronically underfunded and the addition of these GME slots would be beneficial towards expanding care to our patient population. Our system faces a chronic provider shortage, and these spots would not only help alleviate that shortage but would also serve as a vehicle for providing young doctors with exposure to the issues faced by Indian Country. It

¹¹ The Indian Health Service reports that 28 hospitals complete Medicare cost reports.

¹² 25 U.S.C. § 1641.

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is our hope and belief that exposure to Indian Country will make it more likely that a doctor may choose to practice there in the long term.

Further, the United States has a unique trust obligation to Indian Country, which includes ensuring access to health care. Ensuring that Indian Country has access to additional medically trained personnel is in furtherance of ensuring access to health care and important for the long-term health of the Indian health care system. TTAG believes that CMS must set aside a percentage of these new GME positions for Indian Country.

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 ask that CMS work with Congress to remove the 12% cap for all Indian health facilities. In the short term and to the extent allowable without modifying the statute, we recommend CMS develop a methodology for calculating uncompensated and charity care that accurately captures uncompensated and charity care provided by Indian health care providers. Delayed implementation of the proposed changes for our facilities. 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.

Thank you in advance for your consideration of these comments and we look forward to further engagement with CMS on these concerns.

Sincerely,



W. Ron Allen, Chairman
Jamestown S'Klallam Tribe
Tribal Technical Advisory Committee

CC: Kitty Marx, Director, CMS-DTA
Devin Delrow, Associate Director, HHS-IEA