

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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February 24, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via regulations.gov

Re: Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Final Rule with Comment Period (CMS-1752-FC3)

Dear Dr. Brooks-LaSure:

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) final rule with comment period, “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; Changes to Medicare Graduate Medical Education Payments for Teaching Hospitals; Changes to Organ Acquisition Payment Policies.”

The TTAG continues to work toward a Medicare system that works with the Tribal health care delivery system and improves the health of American Indian and Alaska Native (AI/AN) people across this nation. Indian health care providers are often located in some of the most rural areas of the country and face significant recruiting and retention challenges. These challenges are exacerbated by the chronic underfunding of the Indian health system. Tribal health programs are often most successful in recruiting and retaining talent by growing their own talent from their own communities. The Medicare Graduate Medical Education (GME) payment system can become an important part of that process if it is adapted for Indian health care providers.

We would like to thank CMS for recognizing the unique nature of the Indian health system and for responding favorably to the request that CMS prioritize placements at Indian health care providers:

We have considered the comment suggesting that all Indian and Tribal facilities be considered for prioritization regardless of where they are located. Given the unique relationship between the Medicare program and Indian and Tribal facilities, and the health care disparities that exist for the Indian and Tribal populations served by these facilities, we believe it would be appropriate to also prioritize applications for programs where the residents rotate into these facilities. Specifically, for purposes of prioritization we will allow the training time spent in Indian and Tribal facilities outside of a HPSA to count towards the minimum training time criterion for that

HPSA, up to a maximum of 45 percentage points of the 50 percentage points required.

We believe this is good start. However, as discussed below, we believe more is needed, and request that CMS engage with Tribes earlier in the process when developing rules like these.

This rule will be used as the vehicle for implementing the Consolidated Appropriations Act of 2021's creation of 1,000 new GME positions over the next five years. While we agree that Indian health providers would likely 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 because of the program requirements that are not conducive to the unique Indian healthcare system. Therefore, we recommend that CMS also develop set asides for Indian health care providers in the new GME slots.

In the alternative, TTAG supports the development of a separate but parallel Tribal GME program. There are many factors that influence the disconnect between the broader GME program and its impact on Indian Country. A few of the factors include a lack of resources to support bringing in and sustaining GME programs, the capital costs to support residents in current GME programs, cost-reporting requirements, and various other issues which create barriers for some Tribal health facilities to attract and support these residency placements.

Recommendations:

I. TTAG recommends CMS consider the unique nature of Indian health care and factor that into these rules by offering flexibilities or exemptions for Tribes

One of the goals of this 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 unique nature of Tribal health and the Indian healthcare system as a whole.

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 U.S. Constitution, the federal government's unique responsibilities to Tribal nations have been repeatedly reaffirmed by the Supreme Court, legislation, executive orders and regulations.¹ 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 [T]ribes and people."

The trust responsibility establishes a clear relationship between the Tribes and the federal government.² The federal government is responsible for ensuring the health of the Indian health

¹ 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).

² 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.

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 Indian Health Service (IHS) and Tribal (I/T) system has been severely and chronically underfunded for many years. Congress authorized the I/T system to bill Medicare as a way to increase federal funding to the I/T system and to bring it into compliance with Conditions of Participation (CoPs). 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 copays to AI/AN patients.³ 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, 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.⁴ 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.

II. TTAG recommends that CMS create a Tribal set-aside for the newly created GME slots

The TTAG would like to see CMS exercise its discretion and create a set-aside for Indian health care providers. Both IHS and Tribal facilities have run into challenges with navigating sustainable residency program funding sources. As mentioned above, the Indian healthcare 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 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 healthcare system. We believe that CMS must set aside a percentage of these new GME positions for Indian Country.

³ The IHS is prohibited from charging any Indian for services, including copays, 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 copays from the IHS eligible Medicare beneficiaries they serve.

⁴ 25 U.S.C. § 1623(b).

III. In the alternative to the above recommendations, TTAG recommends CMS develop a Tribal GME program

As discussed above, the GME program does not fit with the Tribal healthcare system. In order to account for the unique nature of Tribal health care delivery, billing, and reimbursement, along with the heightened issues with recruitment and retainment of staff, CMS should consider developing a Tribal GME program specifically for Tribal facilities, through Tribal consultation. As reiterated time and time again by Tribal nations, this consultation must be genuine, robust, and meaningful, creating a space for actual conversation and consultation between Tribal nations and the federal government. We hope that the agency, moving forward, prioritizes Tribal consultation while developing such programs as this.

Conclusion

The TTAG looks forward to the continued partnership and work with CMS in developing policies and programs that work for and with the Tribal healthcare system, in accordance with the nation's trust responsibility to provide for the health of Tribal nations. We appreciate the acknowledgment that Indian and Tribal facilities should be considered for prioritization regardless of where they are located, given the unique relationship between the Medicare program and Indian and Tribal facilities and the health care disparities that exist for the populations served by those facilities. We appreciate your consideration of the above comments and recommendations and look forward to engaging with the agency further.

Sincerely,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is written in a cursive, flowing style.

W. Ron Allen, CMS/TTAG Chair
Jamestown S'Klallam Tribe, Chairman/CEO