

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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June 17, 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: 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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

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) proposed rule with comment period, “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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation” (CMS-1771-P). We ask that CMS consider the following comments and concerns from the TTAG and urge CMS to continue to engage the TTAG in addressing the issues regarding the changes to the Inpatient Prospective Payment System (IPPS) in this rule.

Uncompensated Care Payment Structure

While we appreciate the work that CMS has done to develop a system to fairly compensate for the services provided to our patients, we have some questions and concerns to share with you. We ask that any change to the payment formula be fair and adequate to make whole Indian Health Service (IHS) and Tribal hospitals and offset the loss of the previous payment that used proxy data in the calculation. While we understand that it is the position of CMS that the new payment structure would give us a “harmless system,” and we understand that IHS has seen the analysis on this structure and is neutral on the changes, we would like to confirm this. The American Health Association (AHA) recently published an article stating that “hospitals would actually see a new decrease in payments from 2022 to 2023 under this proposal because of proposed cuts to

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disproportionate share hospital (DSH) and other payments.”¹ Therefore, for the sake of the Tribal nations we advocate for, we want to ensure that this change does not negatively impact IHS and Tribal hospitals.

Further, there are other terms in the proposed rule that concern us. For instance, we believe it is inequitable to only provide the new supplemental payment to existing hospitals and not to future builds. It was explained to us at the May TTAG call that the rationale behind this is that the supplemental payment is meant to mitigate the financial loss of the *current* hospitals experiencing the loss of the proxy payment. However, it seems unlikely that this stance could be sustained as fair and equitable. The same type of financial burden would be felt by the future hospital as is felt by existing hospitals. Future IHS/Tribal hospitals will provide the same services to the same populations and therefore experience the same cost burdens as existing hospitals that these supplemental payments are designed to mitigate. We understand that new builds are few and far between, but that does not mean that they do not occur. If this payment structure is truly meant to be a permanent solution, as was stated by CMS at the May TTAG, then we must look to the future and plan for the new hospitals to be built. We can embrace and support providing supplemental payments only to existing hospitals as an interim measure, pending establishing a system that works for *all* IHS and Tribal hospitals now and in the future. In order to stand true with the CMS commitment to pursuing health equity for all, we hope that CMS will either reconsider this provision of the rule, or pledge to work with the TTAG to devise a methodology that will be equitable for both existing and future IHS/Tribal hospitals.

We also recommend that if IHS/Tribal hospitals prefer to be paid under the proposed new structure in the same manner as non-Tribal hospitals, they be allowed to do so. We ask that CMS confirm that they will enjoy that option.

Low-Volume Adjustment

For qualifying hospitals with fewer than 3,800 discharges but more than 500 discharges, the low-volume payment adjustment is calculated by subtracting from 25 percent the proportion of payments associated with the discharges in excess of 500. Under current law, the temporary change in payments for low-volume hospitals are set to expire in FY 2023. In the past, these payments have been extended by legislation, but if they were to expire CMS estimates that payments to these hospitals would decrease by \$600 million.² The IHS is predicting that there could be a \$7.5 million loss at federal IHS hospitals and a potential \$5 million loss at Tribal hospitals annually. As the Indian healthcare system is already chronically underfunded, these additional losses would significantly impact the care provided to our people. We ask that this adjustment be extended, and that CMS not allow this to expire.

¹ CMS issues hospital IPPS proposed rule for FY 2023, AHA News, Apr 18, 2022.

<https://www.aha.org/news/headline/2022-04-18-cms-issues-hospital-ipp-pps-proposed-rule-fy-2023>.

² Fact Sheet: FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P. April 18, 2022. <https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipp-pps-and-long-term-care-hospitals-ltch-pps>.

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Safe Birthing and Maternal Safety Designation

We request that CMS consider exempting Indian health care providers from this safe birthing designation. We do not believe that this reporting 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 potential inaccurate picture created by this formula would paint a negative picture of the Indian health care system, undermining confidence in the quality of care provided mothers and their children. CMS should consider an alternative rating system, or exempting Indian health care facilities altogether, to account for these concerns and avoid inaccurate facility scoring.

The TTAG has reason to be concerned about this. For years now, the TTAG has been advocating that CMS needs to change the formula it uses to calculate hospital acquired condition (HAC) penalties because it unfairly penalizes low volume hospitals including IHS and Tribal facilities. CMS should not compound the error it made with the HAC formula with this new safe birthing designation.

Reporting Requirements

We also request that any reporting requirements imposed by any final rule that comes from this proposed rule be supported by funding. As you know, IHS and Tribal facilities are often understaffed and underfunded, and therefore the burden on them is higher when it comes to designating reporting duties to staff.

Conclusion

We appreciate your consideration of the above comments and recommendations and look forward to engaging with the agency further.

Sincerely,



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