Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 50 F Street NW | Washington, DC 20001 | (202) 507-4070 | (202) 507-4071 fax

January 24, 2025

The Honorable Christi A. Grimm
Inspector General
Office of Inspector General
Department of Health and Human Services
330 Independence Avenue SW
Washington, DC 20201

Submitted via regulations.gov

Re: Solicitation of Proposals for New and Modified Safe Harbors and Special Fraud Alerts (88 FR 93545)

Dear Inspector General Grimm:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), I write to provide a response to the "Solicitation of Proposals for New and Modified Safe Harbors and Special Fraud Alerts" (88 FR 93545). Since 2012, TTAG leadership has requested the Office of Inspector General (OIG) develop safe harbor regulations for Indian Health Care Providers (IHCPs). The OIG has not acted upon this recommendation and has not provided a reasonable basis for the denial. As a result, the TTAG has developed an Indian-specific safe harbor text to the anti-kickback statute that is based on the safe harbor text for Federally Qualified Health Centers (FQHCs) – to benefit American Indian and Alaska Native (AI/AN) people who are a medically underserved population. We again request you to extend this critical protection to IHCPs.

IHCPs are part of a federally designated and funded comprehensive health service delivery system that works to raise the health status of AI/AN populations. AI/AN people are a protected class and considered a political status[1] with Tribal Nations holding a unique government-to-government relationship with the United States. IHCPs serve individuals at or below the Federal Poverty Level (FPL), serve individuals in Health Professional Shortage Areas (HPSA), and isolated areas with limited access to medical care. Despite serving vulnerable populations, only outpatient clinics operated by Tribes under the Indian Self-Determination and Education Assistance Act (ISDEAA) and Urban Indian Organizations contracting with IHS under Title V of IHCIA are defined to be FQHCs under the Social Security Act. Many Tribes attempt an FQHC status but are denied without additional technical assistance or resources to achieve this status. Further, Tribal hospitals cannot enroll as an FQHC, and therefore cannot access the FQHC safe harbor. IHCPs require a dedicated and specific anti-kickback safe harbor

[1] Morton v. Mancari.

that will allow them to enter arrangements to accept goods, items, services, donations, or loans from willing providers and suppliers. Under existing conditions, IHCPs are underfunded, and their resources are constrained, impacting the quality of care delivered to AI/AN people.

Further denial of safe harbor protection for IHCPs is perplexing, given that these facilities share all of the attributes cited by the OIG in its final rule establishing the FQHC safe harbor, except for the barriers cited above. In alignment with the criteria for modifying and establishing safe harbor provisions: (a) IHCPs increase access to health services for AI/AN populations, including 147 Alaska Village clinics; (b) IHCPs provide culturally appropriate and quality health care services to Natives and non-Natives with over 700 facilities available; (c) IHCPs allow for patient freedom of choice among health care providers; (d) IHCPs increase competition among health care programs; (e) IHCPs decrease the cost to Federal health care programs like emergency room visits; (f) IHCPs decrease the potential overutilization of health care services, and; (g) IHCPs increase the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

IHCPs are like FQHCs as they uphold federal statutory and regulatory requirements to operate their services and invest all their federal funding and program revenue back into the health care services delivered to their patients. IHCPs are undoubtedly essential to improving the health status of AI/AN populations and offer parallel services delivered by FQHCs.

The TTAG leadership urges you to reconsider our request to uphold the federal government's trust responsibility to provide for the health and well-being of AI/AN people. We encourage the OIG to re-review our previous comment letters submitted to calls OIG-120-N (2012), (OIG-403-P3 (2014), OIG-123-N (2015), OIG-128-N (2021), OIG-1123-N (2024). Further, we invite you to meet with us on this critical issue at your soonest convenience.

Sincerely,

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