Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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June 9, 2023

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

Submitted via regulations.gov

Re: Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership

Dear Administrator Brooks-LaSure:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), I write to provide a response to the CMS proposed rule "Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership" (CMS-1785-P).

We ask that CMS consider the following comments and recommendation from the TTAG and urge CMS to continue to engage the TTAG in addressing them, in line with the Tribal priorities submitted to CMS leadership in March 2023.[1] The unique nature of the Indian health system requires a creative and unique approach.

[1] Email from AC Locklear, c/o the Centers for Medicare and Medicaid Services (CMS) TTAG Chair W. Ron Allen, to CMS Administrator Chiquita Brooks-LaSure, *CMS TTAG Letter Regarding Tribal Priorities* (March 3, 2023) (copied on email correspondence: Meena Seshamani, Director, Center for Medicare; Dan Tsai, Deputy Administrator and Director, Center for Medicaid and CHIP Services; and Kitty Marx, Director, CMS Division of Tribal Affairs).

Recommendations:

I. Health Equity Impacts

As noted in its National Quality Strategy, CMS has committed to addressing the disparities that underlie the healthcare system, both within and across settings, to ensure equitable access and care for all. Important to CMS's efforts to promote health equity is to consider the unique nature of Indian health in considering comments received on the topic, and specifically on this proposed rule's RFIs both on the Safety-Net Hospitals and on Potential Additional Changes to the Hospital VBP Program That Would Address Health Equity.

Before providing insight into any policy, it is important we highlight the important context in which TTAG's comments are offered, and which should inform CMS's consideration of them: the deep inequities in this nation's health care delivery system, and the Biden administration's commitment and urgent effort to eliminate them. Over the last year the entire federal government, including CMS, has been working to respond to the President's Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (EO 13985). For the first time, the federal government is taking a systematic approach to address equity issues.

Important to understand about health disparities is that AI/AN people were once one of the healthiest people on this continent, before colonialism and the U.S. policies of termination, assimilation, and boarding schools caused an "intergenerational pattern of cultural and familial disruption"[1] that drive health disparities today. These drivers have manifested in some of the worst health disparities for AI/AN people, including disproportionate rates of infant and maternal mortality, cancer, cardiovascular disease, depression, and other behavioral health conditions. The recent Department of the Interior Boarding School Report explains that "Native Americans continue to rank near the bottom of all Americans in terms of health, education, and employment. Many AI/ANs face unique challenges and harsh living conditions resulting from the United States having removed their tribes to locations without access to adequate resources and basic infrastructure upon which their tribal governments can foster thriving communities."[2]

It is important to acknowledge that efforts to address these disparities are often complicated by culturally inappropriate interventions and an inadequate understanding of the historical effects of U.S. policies and ongoing trauma of AI/AN people.[3] It is this history that is the root cause of the significant health disparities that affect AI/AN populations.

The TTAG has always taken the position that CMS has ample legal authority to undertake distinct policies and programs specifically focused on AI/AN beneficiaries and the IHS programs that provide their care, because of their unique legal status under the U.S. Constitution and the duties owed by the federal government under its treaty and trust responsibilities to AI/ANs.

Under established principles of Indian law, programs and policies that are specifically established for Indigenous people and organizations do not constitute prohibited race-based classifications; rather, they are based on the unique political relationship between the federal government and Indian Tribes.

This unique legal relationship, taken together with EO 13985 and CMS' Framework for Health Equity, provides a sound basis for CMS to adopt the TTAG recommendations on this proposed rule. We trust you will agree that the TTAG recommendations are directly related to CMS' Framework discussed in "Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps." The TTAG's recommendations fit clearly in the intended outcomes of this chapter of the Framework as well as other priority areas of the Framework.

II. Rural Emergency Hospital Graduate Medical Education Programs

We support the agency's proposal to allow Critical Access Hospitals (CAHs) that convert to Rural Emergency Hospitals (REHs) to retain their Graduate Medical Education (GME) residency training programs. The designation of REHs as GME eligible facilities is a perfect example of how a flexible policy can increase access to physicians in rural areas. This reduces barriers to Tribal facilities that may be considering a redesignation to an REH, by eliminating one of the cons from the equation, i.e., deciding whether it can cut its training program and continue providing adequate care to its patient populations.

As this new provider type rolls out, we must continue to address the concerns that come up from Tribal facilities to ensure the REH operated how it's intended to, in order to best serve folks in rural areas. One of these identified concerns is that the REH payment structure does not include the all-inclusive encounter rate, so the new provider type is not as attractive as it could be to IHCPs. These are the kinds of issues that come up and can be addressed when CMS engages with Tribes.

III. Request for Information: Safety-Net Hospitals

When settling on the definition of a "safety-net hospital," it is important for the agency to keep in mind the various ways that an area can be underserved. This goes beyond the inclusion of CAHs and REHs, which serve rural and underserved communities by reducing health disparities in areas that may not be able to sustain a full-service hospital and to reduce the financial vulnerability of rural hospitals and improve access to services. Rurality and distance to hospitals are not the only barriers to access, CMS should consider lack of transportation infrastructure, harsh weather conditions that limit access to hospitals during periods of the year, workforce shortages, stigma and bias in the medical community, and other barriers that are less obvious than geographic location.

Any definition that limits the definition to providers that furnish a substantial share of services to low-income patients fails to include a wide array of folks served by such facilities. There exists a wide range of factors that determine an underserved

community, or one that lacks access to vital services. A prime and common example from Indian Country is the income and cost of living discrepancies that exist in different regions across the nation. In some areas, like the more remote regions of Alaska, what would be considered "high income" is not considered high in Alaska. Further, low income does not equal underserved. Considering only the income levels of a population goes against the tenants of health equity; low income does not equal low access.

This decision requires the unique insight of various populations, including the Tribal community. With this perspective, we encourage CMS to engage with communities to ensure the definition catches all underserved folks. The chronic underfunding of the Indian healthcare system compounds the need to support IHS, Tribal, and Urban (I/T/U) facilities. This can be accomplished by auto-designating I/T/U facilities as safety-net hospitals. This would track with the auto-designation as Health Professional Shortage Area (HPSA) designated facilities. HPSA designated facilities, which identify areas, populations groups, or facilities within the U.S. that experience a shortage of health care professionals, would also be another group to include in this definition.

Maintaining a stable clinical workforce capable of providing quality and timely care is critical for IHS to ensure that comprehensive health services are available and accessible to AI/AN people.[2] Chronic underfunding of the Indian health system has contributed to significant vacancy rates for clinical care providers. The pandemic has further strained our healthcare system and has significantly impacted the workforce in many rural and underserved communities, which often include AI/AN reservations and communities. Unfortunately, the Indian health system faces considerable challenges to overcome its longstanding struggle to fill vacancies despite our continued efforts to recruit and retain providers in underserved areas.

Much of Indian Country is rural. In fact, 46.1 percent of AI/ANs live in rural communities, a rate which is more than twice that of the overall U.S. population.[3] The ongoing physician workforce shortage has disproportionately impacted the ability of AI/ANs to access quality health care. Health systems all over the country, including I/T/Us, are in desperate need of additional providers. I/T/U facilities, as well as others in rural areas, face these challenges due to a lack of housing, competitive compensation, and other incentives to draw providers to the region.

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[2] GAO Report to Congressional Requesters, "IHS: Agency Faces Ongoing Challenges Filling Provider Vacancies," Aug. 2018, https://www.gao.gov/assets/gao-18-580.pdf.

[3] Janice C. Probst, Fozia Ajmal, "Social Determinants of Health among Rural American Indian and Alaska Native Populations," Univ. of S.C. Rural and Minority Health Research Center, July 2019 https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/socialdeterminantsofhealthamongruralamericanindianandalaskanativepopulations.pdf.

IV. Ensure the Hospital Acquired Condition formula does not harm IHS/Tribal Hospitals (low-volume)

The Hospital Acquired Condition (HAC) Reduction Program is aimed at improving patient safety by applying a one percent payment reduction to hospitals that rank in the lowest performing percentage of all subsection (d) hospitals with respect to the occurrence of HACs that appear during an applicable hospital stay. These HACs are a group of reasonably preventable conditions selected by CMS that patients did not have upon admission to a hospital, but which developed during the hospital stay.

The HAC program has three measures identified in the IPPS rule:

- AHRQ Patient Safety Measures (Domain 1) weighted at 35%
- Patient safety indicators (PSI) 90 composite measure (8 measures)
- HAC Infections (Domain 2) is weighted at 65%

Payment adjustments will impact hospitals that rank among the lowest performing 25%.

The Centers for Disease Control and Prevention (CDC) formula that is utilized to calculate Standardized Infection Ratio (SIR) is to divide the hospital's reported number of healthcare-associated infections (HAIs) by a hospital's predicted number of HAIs. **A hospital's number of predicted HAIs must be greater than or equal to one in order to calculate an SIR.**

If a hospital has insufficient data which results in the CDC not calculating an SIR for this measure and does not calculate into the Domain 2 score or Total HAC score and results in the hospital having zero in Domain 2, Domain 1 is weighted at 100%, instead of 35%.

With national programs such as 'Target Zero,' 100,000 Lives, and Campaign ZERO promoting and striving to reduce medical errors and hospital acquired conditions to zero, it is unfortunate that a facility that achieves zero HAIs would be removed from the Domain 2 weight. The formula is erroneous in that it does not account for – or weight is not applied appropriately – if your health facility's Domain 2 score is zero. Solutions would be to:

- Assign a score to a zero rate, such as 0.0001, or
- Only apply the 35% weighted score to Domain 1, not the total of 100%

In 2015, Acting Administrator Andrew Slavitt wrote that CMS is working with CDC and others to evaluate an alternative analytic method that potentially could be used in the HAC Reduction program. Any changes to the scoring methodology would require CMS to do so through the rulemaking process.

Since then, numerous attempts have been made by TTAG and CMS staff to make accommodations for low-volume hospitals. However, these attempts have not accomplished the goal. The reason is that the formula developed by CDC is faulty and punishes low-volume hospitals. Congress should step in and require the CDC to revise its formula that more equitably accommodates the circumstances of Indian and other low-volume hospitals.

Proposed Legislative Language:

42 U.S.C. 1395ww(p)(2) is amended by adding the following at the end of subsection (2)(B)(ii):

In implementing this provision, the Secretary shall adapt its risk adjustment methodology so that low volume hospitals are able to have HAC infections weighted at 65 percent even if their predicted HAC infection rate is less than one.

V. Uncompensated Care

We appreciate that the Agency recognized the importance of the supplemental payment for Indian Health Service (IHS) and Tribal (I/T) hospitals for FY 2023. We maintain that the supplemental payment is a necessary result of the unique challenges we face with respect to uncompensated care due to structural differences in health care delivery and financing compared to the rest of the country. Based on analysis conducted by the IHS, we are confident that this new permanent supplemental payment will mitigate the anticipated impact on I/T hospitals due to the discontinuance of the previous methodology for calculating uncompensated care costs. We are hopeful that this supplemental payment will mitigate the undue long-term financial disruption that would have occurred.

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