



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

September 11, 2023

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: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction

Dear Administrator 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, “Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction” (CMS-1786-P).

We agree with CMS that current Medicare reimbursement policies that do not address high-cost drugs and specialty care “threatens the viability of the few IHS and tribally owned hospital outpatient specialty programs currently in operation and provide less incentive to IHS hospitals and tribally-owned facilities not currently offering specialty services to begin doing so.” We are thankful that CMS has recognized this issue and is actively seeking comment on number of potential policies to address payment to IHS and tribally operated facilities for certain high-cost drugs and services. While the TTAG support this rulemaking, we have the following comments and recommendations that we hope the agency will consider it takes into account the unique impact of this proposal on Indian Country and the unique needs of our people.

Health Equity Preamble:

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.

It is 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" 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."

Recognizing 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. 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 within the intended outcomes of this chapter of the Framework as well as other priority areas of the Framework.

Comments and Recommendations:

I. Permit I/T Facilities that Convert to REHs to be Paid the Same All-Inclusive Rate Otherwise Available to Them

We appreciate the attention that CMS has given the TTAG's comments on concerns with the impacts of converting to a Rural Emergency Hospital (REH). In proposing that Indian Health Service (IHS) and Tribal (I/T) facilities that convert to REHs be paid for hospital outpatient services under the same AIR that would otherwise apply if these services were performed by an I/T hospital that is not an REH, the agency makes it clear that it understands our concern and that it is a true partner to Tribal nations. We appreciate this consideration and the TTAG fully supports this proposal.

The TTAG also supports the proposal that I/T facilities that convert to REHs would receive the REH monthly facility payment consistent with how this payment is applied to REHs that are not I/T operated. CMS expects this approach, if finalized, would bring further stability to IHS facilities that decide to convert to REHs and better promote access.

However, the TTAG has some concerns over the way this proposal is currently written. The agency's proposed definition of the term "IHS and tribally-operated REHs" needs to be corrected. The definition mistakenly references funding authorized "by Title I or Title III" of the ISDEAA, when it should instead reference funding authorized "by Title I or Title V" of ISDEAA.

The proposed definition at 42 CFR 419.92(e) should be corrected as follows:
IHS or tribally operated REHs. An Indian Health Service (IHS) or tribally operated REH is an REH, as defined in §485.502 of this chapter, that is operated by the IHS or by a tribe or tribal organization with funding authorized by Title I or Title V of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638.)

Or, to be a bit more precise, and to more closely adhere to the definition of the term "tribal health program" in Section 4 of the Indian Health Care Improvement Act (IHCIA), it should be revised to read as follows:

IHS or tribally operated REHs. An Indian Health Service (IHS) or tribally operated REH is an REH, as defined in §485.502 of this chapter, that is operated by the IHS or by a tribe or tribal organization with funding authorized by, or that is provided for in a contract or funding agreement entered into pursuant to, Title I or Title V of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638, as amended.)

In addition, this proposal would not give Tribally operated facilities the option to be paid as other REHs are – under the OPPS+ monthly fee. Tribally operated REHs should have that same option. To accomplish this, we recommend revising proposed 42 CFR 419.92(d) as follows:

(d) *Payment for IHS or tribally operated REHs.* An Indian Health Service (IHS) or tribally operated REH, as defined in paragraph (e) of this section, will be paid under the outpatient hospital All-Inclusive Rate that is established and published annually by the IHS , or, at its option, ~~[rather than]~~ at the same rates for REH services described in paragraph (c)(1) of this section.

II. Separate Payment for High-Cost Drugs and Services Provided by Indian Health Service and Tribally Owned Facilities

The IHS and Tribal facilities operating under Indian Self-Determination and Education Assistance Act (ISDEAA) agreements are authorized to bill the Medicaid and Medicare programs at cost-based rates known as the IHS All-Inclusive or Encounter rates (the IHS AIR). The IHS AIR is critically important to the Indian health system and must be preserved. The IHS AIR is based on cost-reports collected by the IHS and reviewed and approved by the Office of Management and Budget and published in the Federal Register on an annual basis. CMS exempted IHS and Tribal facilities from billing at the OPPS rates in order to preserve their ability to continue to bill at the IHS AIR Encounter rates. This exemption is critically important, and must remain in place to ensure that IHS and Tribal facilities can continue to bill at the IHS AIR.

However, the IHS AIR does not currently adequately reimburse IHS and tribal facilities for certain high-cost services. IHS and Tribal facilities have continued to expand the breadth of services that they provide to their communities, which can mean providing higher-cost drugs along with more complex and expensive services. We are glad CMS is seeking comment on additional payment approaches that would enhance its ability to provide equitable payment for high-cost drugs and services provided by I/T facilities. We agree with CMS that if providing a drug costs a specialty facility exponentially more than the payment rate as reflected in the AIR, it is not financially feasible to expect the facility to continue to provide those services.

Various IHS and Tribal facilities incur significant costs each time it administers such drugs, which the AIR does not come close to covering. Therefore, the TTAG supports the creation of a mechanism by which Medicare can pay separately for high-cost drugs provided by IHS and Tribal facilities. Setting a cost threshold may be advantageous as compared to attempting to identify each and every drug that should be covered by this new, separate payment mechanism. This would not only be more straightforward for CMS, but it would allow Tribal and IHS facilities to have a consistent expectation for reimbursement of services provided.

We thank CMS for raising the question. The TTAG recommends establishing separate payment immediately for certain exceedingly high-cost drugs, including all oncology and outpatient infusion service drugs that exceed the AIR rate. We urge CMS to implement separate payment for these drugs immediately.

Whether to pay separately for other drugs and services, and under what methodology, are complex issues with big implications for IHS and Tribal facilities nationwide. The correct way to consider these issues is to engage in Tribal consultation and robust discussion with the TTAG, where we can all better explore the options, nuances, and implications of such a mechanism. Among other things, our TTAG leadership would need to better understand whether and to what extent such a change would impact the AIR. We invite CMS to attend the next in-person TTAG meeting in October 2023 to begin the discussions on how to proceed.

We know that one example is a state that currently provides IHS and Tribal facilities with the Medicaid AIR for each patient visit to pharmacy. However, if the cost of any single covered drug is greater than the AIR, the Medicaid program reimburses separately for that drug at acquisition cost plus a dispensing fee. This separate payment mechanism was approved by CMS in a State Plan Amendment. In this model, the cost threshold would be tied to the AIR, which is already updated annually on the national level. If the cost of an oncology drug exceeded the AIR, then the drug would be reimbursed through a separate payment mechanism.

III. OMB Rate for Grandfathered Federally Qualified Health Centers

The TTAG supports the proposal to pay Grandfathered Tribal Federally Qualified Health Centers (FQHC) for their Intensive Outpatient Services (IOP) at 80 percent of the lesser of their actual charge or the OMB rate – that is, at the same rate as for their covered FQHC services. Paying the OMB rate to Grandfathered Tribal FQHCs – rather than a separate rate – is appropriate because by statute, FQHCs must be paid for their IOP services at an amount “equal to the amount that would have been paid to an outpatient hospital department” for IOP services, and the OMB rate is based on IHS and Tribal outpatient hospital costs.

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, appearing to read "W. Ron Allen". The signature is fluid and cursive, with the first name "W." and last name "Allen" clearly distinguishable.

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