Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

June 10, 2020

Mr. Demetrios Kouzoukas,
Principal Deputy Administrator for Medicare and Director
7500 Security Blvd,
Baltimore, MD 21244

Re: Request for CMS Rulemaking: Making the IHS Medicare Outpatient Encounter Rate Available to All Indian Outpatient Programs.

Dear Administrator Kouzoukas:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), we write to ask that CMS amend its Medicare regulations to make all Indian outpatient facilities eligible for reimbursement at the Indian Health Service (IHS) Medicare outpatient encounter rate, regardless whether and when they were owned, operated, or leased by IHS, and without requiring Tribal Federally Qualified Health Centers (FQHC) to submit cost reports that have nothing to do with their reimbursement methodology. CMS has been inching in this direction for nearly twenty years, and we believe it is time to bring the process to its logical and equitable conclusion by making all Indian outpatient programs eligible for encounter rate reimbursement.[1]

Under the current rules, an Indian outpatient facility's reimbursement now depends on historical quirks over which it had no control and that have little to do with its relative operating costs. Currently, otherwise similar clinics are paid at dramatically different rates depending upon whether they qualify as a "provider based facility," a "grandfathered Tribal FQHC," a non-grandfathered Tribal FQHC, or none of the above—categories that largely depend on whether and when the facility was last operated by the IHS. Consequently, otherwise similar Indian outpatient clinics are now paid at dramatically different rates, and modern new clinics may be paid at lower rates than older ones that are less costly to operate.

The current rules reflect CMS's efforts over the years to mitigate the financial impact on Indian facilities of changes to CMS's provider-based rules and to CMS's application of the hospital Conditions of Participation (CoPs). We recognize and applaud those efforts. But because CMS responded narrowly to

[1] This request builds on the TTAG's previous correspondence and public comment on proposed changes to the provider-based and grandfathered tribal FQHC rules, including (1) our June 13, 2017 comments on the FY 2018 Medicare IPPS proposed rules (CMS-1677-P), https://www.nihb.org/tribalhealthreform/wp-content/uploads/2017/06/TTAG-Medicare-IPPS_FY-2018_GrandfatheredFQHC-PR-Comment.pdf; (2) our September 6, 2016 comments on proposed changes to the Hospital OPPS and ASC payment systems (CMS 1656-P), https://www.nihb.org/tribalhealthreform/wp-content/uploads/2016/09/TTAG-Comments-on-CMS-1656-P-9.6.2016.pdf; (3) our October 15, 2015 letter to CMS Hospital and Ambulatory Policy Group Director Marc Hartsein, https://www.nihb.org/tribalhealthreform/wp-content/uploads/2015/10/TTAG-Provider-Based-Letter-to-CMS-3.pdf; (4) our September 8, 2015 comments on CY 2016 proposed changes to Part B (CMS 1631-P), https://www.nihb.org/tribalhealthreform/wp-content/uploads/2015/10/TTAG-Comment-on-CMS-1631-P.pdf; and (5) our July 9, 2015 letter to Mr. Hartstein and Division of Acute Care Services Director Marilyn Dahl regarding provider-based status for IHS and tribal facilities, https://www.nihb.org/tribalhealthreform/wp-content/uploads/2015/07/TTAG-Letter-re-Provider-Base.pdf.

each change as it arose, Indian facilities are now paid under a crazy quilt of reimbursement rules that create inequities and defy common sense.

The brief history is this:

- Before April 7, 2000, there were few requirements for an outpatient program to qualify for "provider-based" status. Most IHS clinics' Medicare services were billed and paid at the IHS outpatient hospital rate and, when Tribes assumed operation of those clinics or their associated hospitals under the Indian Self Determination and Education Assistance Act (ISDEAA), they continued to be paid the same way.
- Effective April 7, 2000, CMS dramatically tightened the provider-based requirements. But to prevent significant harm to Indian programs, it also "grandfathered" in some IHS and Tribal clinics. That protection was needed because the new regulations (42 C.F.R. 413.65) included requirements that many IHS and Tribally operated clinics could not meet, such as clinical, financial, and administrative integration with the associated hospital, and close geographic proximity to it. Had the new rules applied to them, many Tribal and IHS clinics would have experienced a precipitous reduction in Medicare revenue: instead of payment at the IHS encounter rate, they would have been paid either at much lower FQHC rates or only for professional services under the physician fee schedule. To prevent potentially catastrophic harm to the clinics and their patients, the new rules extended provider-based status to clinics operated by the IHS, and to former IHS clinics assumed by Tribes under the ISDEAA, but only to those that (1) were owned or leased by the IHS (clinics that are both Tribally owned and operated were not eligible) and (2) had been billed as provider-based to an IHS or Tribal hospital on or before the rule's effective date of April 7, 2000. (Former 42 C.F.R. 413.65(m).)
- Initially, this "grandfathered provider-based Tribal facility" provision was understood to allow most existing IHS and Tribal clinics to continue to be paid at the IHS Medicare outpatient encounter rate. In subsequent years, however – and over TTAG's objection -- its reach was sharply curtailed by CMS's determination that the provision does not override hospital Conditions of Participation (CoPs), including those that impose requirements very similar to the provider-based requirements from which grandfathered Tribal facilities were exempt. [2] Because the CoPs require hospitals to exercise certain authority over their provider-based clinics, CMS advised IHS hospitals that they would violate their CoPs and face decertification if they continued to allow Tribally-operated clinics to bill as provider-based to the hospital. Tribally-operated hospitals received the same warning with respect to IHS-operated clinics billing as provider-based to the Tribal hospital. This effectively made grandfathered provider-based Tribal status and IHS encounter-rate reimbursement available only to IHS-operated clinics whose hospital was still operated by the IHS, and to tribally-operated clinics whose associated hospital operations had also been assumed by the tribe. All other Indian clinics -- including the many tribally-operated clinics whose hospitals remained under IHS operation, and the smaller number of IHS-operated clinics whose hospitals had been assumed by a

[2] See TTAG's September 8, 2015 comments on CMS-1631-P, the proposed rule that ultimately established grandfathered tribal FQHC status.

Tribe -- were eligible only for much lower payment, either under the physician fee schedule or (for tribal clinics only) at FQHC rates.[3]

- To mitigate the impact of this CoP decision, in 2016, CMS adopted a rule that allows some but not all formerly grandfathered provider-based Tribal clinics to enroll as "grandfathered Tribal FQHCs" and be paid at the IHS encounter rate, rather than at the much lower FQHC Prospective Payment System rates that would otherwise apply. (42 CFR 405.2462(d).)[4] Because FQHCs are not required to be affiliated with hospitals, this resolved the CoP issue for qualifying clinics. However, this new option was not available to IHS-operated clinics, which are ineligible for FQHC status. Further, as was also true at the time for grandfathered provider-based tribal clinics, it was offered only to tribally-operated clinics that had been billed and paid as provider-based to an IHS hospital on or before April 7, 2000. Finally, and even though they would be paid under the IHS encounter rate and not the FQHC PPS rate, grandfathered tribal FQHCs were required to submit the same FQHC cost reports as other FQHCs.

- Less than a year later, in 2017, CMS employed a similar "Tribal FQHC" strategy in the Medicaid program, to mitigate the impact of its own decision on the availability of encounter rate reimbursement in that program. In 2016, CMS determined that the Medicaid "clinic" benefit does not include services furnished outside a facility's "four walls," even though most States had a long history of paying for them at the IHS encounter rate as a Tribal clinic service. [5] As in the Medicare program, CMS recognized the importance of encounter-rate payment to Tribal outpatient programs, and so it found a way to allow States to continue to pay the rate for a Tribal program's off-site services. Noting that the Medicaid FQHC benefit does not have a "four walls" limitation, that Tribal outpatient programs qualify as FQHCs under section 1905(*l*)(2)(B) of the Social Security Act, and that Section 1902(bb)(6) of the Act allows States to adopt "alternative payment methodologies" (APMs) for FQHC services, CMS authorized State Medicaid programs to adopt the IHS encounter rate as an APM for Tribal FQHCs.[6]

- Subsequently, effective January 1, 2018, CMS eliminated the April 7, 2000 date restriction in the grandfathered provider-based Tribal facility rule. Commenting on that proposed rule in 2017, TTAG asked that the date restriction also be removed for grandfathered Tribal FQHCs. While

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[3] Tribally operated outpatient programs qualify as FQHCs under section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)), but IHS-operated outpatient programs do not.

[4] For 2019, the IHS Medicare outpatient encounter rate was $455.00 in the lower-48 states and $682.00 in Alaska, while the 2019 FQHC base PPS rate (without geographic adjustments) was $169.77. FQHC geographic adjustments range from 0.933 (for West Virginia) to 1.321 (for Alaska).

[5] Because off-site services fall outside the Medicaid "clinic" benefit, CMS concluded they do not qualify for the IHS encounter rate payment that applies to clinic services furnished by Indian programs. CMS Frequently-Asked Questions (FAQs) Federal Funding for Services "Received Through" and IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO # 16-002), January 18, 2017, https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/faq11817.pdf

[6] Several States have already done so.

> CMS declined at the time, explaining that such a change would be outside the scope of the proposed rulemaking, it said it would consider doing so in a future rulemaking. [7]

As you can see, CMS has moved ever closer to paying all Indian outpatient programs at the encounter rate for their covered Medicare and Medicaid services. But as the Medicare rules now stand, eligibility for that rate still depends on historic factors largely outside the control of IHS or the Tribe and unrelated to the facility's relative costs -- including whether and when the facility was previously operated by IHS, how IHS previously billed for its services, whether the facility is owned by the Tribe or by IHS, and whether the Tribe has also assumed operation of the service area's hospital. Today for example, a 60-year old IHS-operated clinic may qualify for payment at the encounter rate, while a brand-new, state-of-the-art Tribally-operated clinic is paid much less; two clinics operated by the same Tribe may be paid differently based on when they were built or assumed from IHS; grandfathered Tribal FQHCs may be paid the encounter rate but only if they file cost reports unrelated to that reimbursement methodology; and while it no longer matters how a facility's services were billed twenty years ago if it seeks encounter rate payment as a provider-based clinic, that twenty-year old billing history is absolutely determinative if it seeks encounter rate payment as a grandfathered Tribal FQHC.

In our view, it both inequitable and nonsensical for Medicare to pay Indian outpatient facilities at different rates based on distinctions that have grown increasingly irrelevant, to deny provider-based Tribal status to clinics that are both owned and operated by a Tribe while allowing that status for Tribally-operated clinics that are owned by IHS, or to require Tribal FQHCs to file pointless cost reports that have no relationship to their IHS encounter rate reimbursement. Instead, we urge CMS to allow all Indian outpatient facilities, at their option, to be paid for their Medicare services at the IHS encounter rate, regardless of their billing and payment history, and to require Tribal FQHCs to file cost reports only to the extent necessary to support payment for non-FQHC services that are reimbursed outside the encounter rate. We recommend this be done as simply as possible, by adding a new regulation to that effect and making conforming amendments to other regulations.

We offer the following draft changes for your consideration.

> ***Amend 42 C.F.R. 405 by adding the following section XXX (new):***
>
> *Notwithstanding any other provision of law, federally-qualified health centers and other outpatient facilities operated by the IHS or by an Indian Tribe or Tribal Organization under the Indian Self-Determination Act (Pub. L. 93-638) may elect to be reimbursed for their covered services at the Medicare outpatient per visit rate as set annually by the IHS[8]. Such facilities shall also be paid separately for covered services furnished outside the scope of the facility benefit under the applicable methodology or fee schedule.*

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[7] CMS-1677-F, 82 Fed. Register 37990 at 38289 (August 4, 2017), https://www.govinfo.gov/content/pkg/FR-2017-08-14/pdf/2017-16434.pdf

[8] The language identifying the encounter rate is taken from the grandfathered tribal FQHC regulation, 42 CFR 405.2462(d). A more exact description would be "*at the applicable Office of Management and Budget (OMB)-negotiated all inclusive rate (AIR) for Medicare outpatient hospital services published annually by the Indian Health Service in the Federal Register.*"

***Amend 42 CFR 405.2462(d) as follows (new language is underlined; deleted language is in brackets and all-caps)*:**

42 C.F.R. 405.2462 (d) *Payment to [GRANDFATHERED] tribal FQHCs*. (1) A "[GRANDFATHERED] tribal FQHC" is a FQHC that:

(i) is operated by a tribe or tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA);

(ii) [WAS BILLING AS IF IT WERE PROVIDER-BASED TO AN IHS HOSPITAL ON OR BEFORE APRIL 7, 2000;] and

[(iii)] Is not operated as a provider-based department of an IHS or tribal hospital.

(2) At the option of the tribe or tribal organization, a [A GRANDFATHERED] tribal FQHC is paid at the Medicare outpatient per visit rate as set annually by the IHS.

(3) The IHS payment rate is not adjusted:

(i) By the FQHC Geographic Adjustment Factor:

(ii) For new patients, annual wellness visits, or initial preventive physical examinations; or

(iii) Annually by the Medicare Economic Index or a FQHC PPS market basket.

(4) The IHS payment rate is adjusted annually by the IHS under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Pub.L. 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 *et seq.*).

(5) A tribal FQHC paid under the IHS payment rate is exempt from the cost-reporting requirements of 42 CFR 405.2470.

(6) A tribal FQHC paid under the IHS payment rate may be paid separately for vaccines and other non-FQHC services under the applicable fee schedules or, for services reimbursed on a facility-specific cost basis, on the basis of limited cost reports addressing those services.

(7) A tribal FQHC may annually elect to be paid instead under the applicable FQHC PPS rate including applicable adjustments.

***Amend 42 C.F.R. 413.65(m) as follows (new language is underlined; deleted language is in brackets and all-caps*):**

42 C.F.R. 413.65. *Requirements for a determination that a facility or an organization has provider-based status. ...*

(m) *Status of Indian Health Service and Tribal facilities and organizations.* Facilities and organizations operated by the Indian Health Services and Tribes will be considered to be departments of hospitals operated by the Indian Health Service or Tribes if they furnish only

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services that are billed, using the CCN of the main provider and with the consent of the main provider, as if they had been furnished by a department of a hospital operated by the Indian Health Service or a tribe and they are:

(1) Owned and operated by the Indian Health Service;

(2) Owned by the Tribe but leased from the Tribe by the IHS under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with the applicable regulations and policies of the Indian Health Service in consultation with Tribes; [OR]

(3) Owned by the Indian Health Service but leased and operated by the Tribe under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with the applicable regulations and policies of the Indian Health Service in consultation with Tribes; or

(4) Owned and operated by the Tribe under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with the applicable regulations and policies of the Indian Health Service in consultation with Tribes.

We appreciate your serious and expeditious consideration of this proposal, which we would be pleased to discuss with you at our next virtual meeting in Washington, D.C. on July 22, 2020 or at your earliest convenience.

Sincerely,

W. Ron Allen
Chairman – Jamestown S'Klallam Tribe
Chairman – CMS Tribal Technical Advisory Group

CC: John Brooks, Principal Deputy Director, Medicare Program
Kitty Marx, Director, CMS Division of Tribal Affairs