



Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

CMS Tribal Technical Advisory Group (TTAG) Tribal Health Priorities

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IHS Tribal Self-Governance Advisory Committee
Self-Governance Communication and Education

Introduction to the Priorities

- November 2020, CMS TTAG submitted a list of policy priorities to the Administrator.
- November 2022, CMS ask CMS TTAG to prioritize and separate into legislative and regulatory.
- CMS TTAG Policy Subcommittee developed small workgroup to complete the task.
- March 2023, CMS TTAG Policy Subcommittee finalized and approved the new priorities.
- March 2023, CMS TTAG approved the new priorities.
- March 2023, CMS TTAG submitted the new TTAG Legislative and Regulatory Policy Priorities to the CMS Administrator.
- The CMS TTAG Policy Subcommittee will work on and track the priorities with CMS Division of Tribal Affairs.



Goals of Policy Priorities

- ❖ Increase third party resources through Medicare, Medicaid, CHIP and ACA reimbursement to Indian health care providers
- ❖ Increase access to coverage for AI/ANs through Medicare, Medicaid, CHIP and ACA Exchange plans
- ❖ Remove barriers to access to coverage for AI/ANs
- ❖ Remove barriers of access to Medicare, Medicaid, CHIP and ACA reimbursements for Indian health care providers



Legislative or Regulatory Change

- ❖ Legislative Change:

- ❖ Some of the TTAG Priorities require the law to be changed, which will require an Act of Congress

- ❖ Regulatory Change:

- ❖ Some of the TTAG Priorities can be achieved through new guidance or a regulatory fix by CMS



Medicare Regulatory Change –

Priority #1: Make the IHS OMB outpatient rate available to all Indian health programs that request it

- ❖ Different tribally operated clinics are reimbursed at dramatically different rates based on whether they qualify as a provider based facility, a grandfathered tribal FQHC, a non-grandfathered tribal FQHC or none of the above.
- ❖ REQUEST – CMS allow all Indian outpatient clinics that request it to be reimbursed at the IHS OMB outpatient rates.
- ❖ RESULT – CMS has met with the TTAG numerous times on this issue but has not taken action on it.



Medicare Regulatory Change – Priority #2: Require Part D plans and PBMs to fully reimburse tribal pharmacies

- ❖ Part D plans and Pharmacy benefit managers are discounting reimbursements to IHS and tribal pharmacies based on their access to federally discounted drug programs and due to new fees.
- ❖ REQUEST – CMS should take action to ensure that Part D plans and PBMs are not discounting reimbursements based on IHS and tribal providers right to access discounted pharmaceuticals.
- ❖ RESULT – CMS has met with the TTAG numerous times to discuss. IHS and tribes have drafted changes to the Part D Indian Addendum to expand it to include PBMs and address these issues. The draft changes are under review by CMS.



Medicare Regulatory Change –

Priority #3A: Payment by Medicare Part C Advantage Plans at the IHS OMB Rate

- ❖ Medicare Advantage Plans are not reimbursing Indian health care providers at the IHS OMB rates, and often not reimbursing them at all.
- ❖ REQUEST – CMS should require all Medicare Advantage plans to be reimbursed at the IHS OMB rates, and to deem all Indian health care providers as in-network even if they do not enroll as participating providers.
- ❖ RESULT – CMS has met with the TTAG numerous times but has not taken action on this request.



Medicare Regulatory Change –

Priority #3B: Protect AI/ANs from Predatory Medicare Advantage Plan and Broker Marketing Techniques

- ❖ Many AI/ANs have been subject to predatory marketing practices by Medicare Advantage plans that do not work well with Indian health care providers.
- ❖ REQUEST – Develop a list of FAQs to ensure Medicare Advantage Plans and Brokers are not using predatory and misleading practices to increase enrollment in Indian country.
- ❖ RESULT – CMS recently published a final rule on Medicare Advantage plans but did not address or even mention the TTAG’s comments on these issues.



Medicare Regulatory Change –

Priority #4: Increase Flexibility in Medicare Definition of Telemedicine Services

- ❖ The telehealth flexibilities Medicare has made available during the public health emergency should be made permanent to the maximum extent possible, and more services should be allowed to be furnished via telehealth. In addition, much of Indian country is in rural areas and lacks access to more advanced methods of audio and video real-time communication, and many AI/AN beneficiaries lack access to smart phones and other audio-video capable devices.
- ❖ REQUEST - Medicare should allow telehealth to be provided through audio-only telephonic and two-way radio communication methods, not only on a case-by-case basis, but more broadly in service areas where access limitations justify its use. This should be allowed for the widest possible array of services, and not only for mental health services.
- ❖ RESULT - The Medicare telehealth flexibilities were extended through FY2024 in the FY2023 Omnibus bill. However, TTAG is requesting CMS provide maximum flexibility in the implementation of these Medicare telehealth flexibilities and make them permanent.



Medicare Regulatory Change –

Priority #5: Exempt I/T/U DME Suppliers from Competitive Bidding Process

- ❖ Indian health care Durable Medical Equipment (DME) suppliers cannot take part in the Competitive Bidding Process, even if they are a Medicare approved supplier because they serve only IHS beneficiaries and the DMEPOS Competitive Bidding process requires that “contract suppliers must agree to accept assignment on all claims for bid items.”
- ❖ REQUEST – Exempt Indian health care DME suppliers from the Competitive Bidding process because it does not recognize that they limit services to IHS beneficiaries.
- ❖ RESULT – No action has been taken on this request, but CMS has indicated it will address the issue in its update to regulations in 2023.



Medicaid Regulatory Change –

Priority #1: Encourage States to Increase Medicaid Telehealth Reimbursement for Indian health care providers

- ❖ States have broad authority to reimburse telehealth services at the same rate as in person services.
- ❖ REQUEST – Issue guidance to states confirming they can authorize Medicaid reimbursement for telehealth services for Indian health care providers at the IHS OMB rates.
- ❖ RESULT – CMS has issued a telehealth toolkit and guidance that confirms that states can reimburse for telehealth services at the same rate as in person services.



Medicaid Regulatory Change –

Priority #2: Approve TTAG Request for Indian Safe Harbor to Anti-Kickback Statute

- ❖ Since 2012, the TTAG has requested that the HHS OIG approve its request for an Indian-specific safe harbor to the Anti-Kickback Statute. Federally qualified health centers have their own safe harbor to the Anti-Kickback Statute. While tribal outpatient clinics are defined by law to be federally qualified health centers, this safe harbor is not broad enough to include all IHS and tribal health care providers, including hospitals. As a result, the TTAG developed an Indian-specific safe harbor to the Anti-Kickback statute that is based on the safe harbor for FQHCs.
- ❖ REQUEST - TTAG has repeatedly requested OIG adopt this safe harbor, but the OIG has declined to do so.
- ❖ RESULT - Most recently, the OIG declined this request in its Fall 2021 Semi-Annual Report, stating without explanation that it believed existing safe harbors were sufficient, but indicating it might consider the topic again in a future rulemaking. TTAG disagrees that existing safe harbors are sufficient, and requests the OIG meet with us and explore the issue in more detail.



Medicaid Regulatory Change –

Priority #3: Extend the grace period and revisit the four walls limitation

- ❖ CMS will begin enforcing a “Four Walls” limitation that prevents IHS/tribal/urban clinics from billing for services outside the four walls of their clinic nine months after the public health emergency ends.
- ❖ The Four Walls limitation is based on a misreading of the social security statute and would prevent IHS and tribal providers enrolled as providers of clinic services from billing the Medicaid program for needed services outside the four walls of the clinic.
- ❖ REQUEST – That CMS extend the grace period and reconsider the policy.
- ❖ RESULT – CMS has extended the grace period to nine months after the public health emergency ends and has allowed clinics to re-designate as federally qualified health centers that do not have the four walls limitation as a workaround, but that re-designation has created issues for tribes in some states. CMS is committed to continuing to work on the issue.



Medicaid Regulatory Change – Priority #4: Protect Indian health care providers from State cuts

- ❖ Due to financial pressures due to the COVID 19 pandemic, States may feel the need to cut Medicaid services.
- ❖ CMS previously approved State waivers that protected Indian health care providers from cuts to Medicaid benefits.
- ❖ REQUEST – If needed, CMS should be willing to entertain similar waivers to protect Indian health care providers from similar cuts or to approve waivers that provide facility based reimbursement for services to AI/ANs received through IHS/tribal facilities.
- ❖ RESULT – CMS has not yet taken action on a pending waiver from Wyoming that would provide facility based reimbursement for services to AI/ANs who have no other form of coverage.



Questions?

Medicare Legislative Change –

Priority #1: Exempt AI/AN from Medicare premiums and cost-sharing and 100% reimbursement for IHCPs

- ❖ The Medicare program generally reimburses providers for 80 percent of the allowable costs of a service, and the remaining 20 percent is paid to the provider by the patient. This means that Indian health care providers only receive 80 percent of Medicare reimbursement.
- ❖ AI/AN have a pre-paid right to health care at no cost to themselves, and are exempt from premiums and cost sharing in Medicaid but not Medicare.
- ❖ REQUEST – Amend Section 1880 of the Social Security Act to clarify that no co-pays, cost sharing or other charge will be charged to an AI/AN Medicare enrollee, and that no Medicare reimbursement to an Indian Health Care provider be reduced by any such co-pay, cost sharing or other charge.
- ❖ RESULT – Not yet introduced.



Medicare Legislative Change –

Priority #2: Include new eligible provider types under Medicare for reimbursement to IHCPs

- ❖ There is a severe, longstanding and well-documented shortage of healthcare providers in Indian country. Because of this, many Indian health care programs rely on other types of licensed professionals, including Pharmacists, Certified Community Health Aides and Practitioners (CHA/Ps), Behavioral Health Aides and Practitioners (BHA/P)s, and Dental Health Aide Therapists (DHATs).
- ❖ REQUEST – Amend Section 1861 of the Social Security Act to define and create new Indian health care program pharmacist and non-physician practitioner services as a reimbursable Medicare service for Indian health care providers.
- ❖ RESULT – Not yet introduced. TTAG was extremely pleased to see the provisions in the 2023 Consolidated Appropriations Act that, effective January 1, 2024, establish Medicare Part B coverage for Marital and Family Therapists (MFTs) and Mental Health Counselors (MHCs) and add them as qualified providers of Federally Qualified Health Center, Rural Health Clinic, and Hospice Program services for both Medicare and Medicaid.



Medicare Legislative Change – **Priority #3: Expand Medicare Telehealth Reimbursement**

- ❖ During the COVID 19 Public Health Emergency, telehealth and tele-behavioral health emerged as critical to providing care to AI/AN people.
- ❖ Medicare was able to reimburse for telehealth services in a patient's home during the public health emergency under waivers.
- ❖ Once the public health emergency ends, telehealth flexibilities for Medicare will end as well, and Medicare will no longer reimburse for certain types of telehealth in a patient's home for example.
- ❖ REQUEST – Approve the CONNECT Act or other legislation that would provide HHS the authority to waive Medicare telehealth restrictions outside of a public health emergency, including the originating site requirement.
- ❖ RESULT – H.R. 4040 Advancing Telehealth Beyond COVID–19 Act of 2021 passed the House of Representatives by a vote of 416-12 on July 27, 2022. Would extend certain telehealth waivers through 2024, but not permanently.



Medicare Legislative Change – Priority #4: Exempt IHS/Tribal Hospitals from Hospital Star Rating System

- ❖ The Hospital Compare system rates hospitals across seven areas of quality into a single star rating. VA and DoD hospitals are exempt from the system.
- ❖ The star rating system unfairly measures IHS and tribal hospitals and does not consider inadequate funding and unmet health needs of the population served.
- ❖ REQUEST – Exempt IHS/tribal hospitals from the star rating system like other federal providers like the VA and DoD.
- ❖ RESULT – Not yet introduced.



Medicare Legislative Change –

Priority #5: Create IHS/Tribal Accommodation under Hospital Acquired Condition Rules

- ❖ CMS uses a complicated formula for determining which hospitals have the lowest performance when it comes to hospital acquired conditions. Under CMS's formula, low volume hospitals like IHS and Tribal hospitals are unfairly designated as low performing even when they are not.
- ❖ REQUEST – Create an accommodation for IHS/Tribal hospitals so that they are no longer identified as low performing with regard to hospital acquired conditions even when they are not.
- ❖ RESULT – CMS has met with the TTAG numerous times but has not changed the formula.



Medicaid Legislative Change –

Priority #1: Authorize Reimbursement for Qualified Indian Provider Services

- ❖ The TTAG has proposed creating a new Medicaid service type called “Qualified Indian Provider Services” that could be billed by any IHS/Tribal/urban provider no matter what State they are in.
- ❖ It would allow I/T/U providers to bill their State Medicaid program for any mandatory or optional Medicaid service as well as for a broad set of health care delivery services authorized in the Indian Health Care Improvement Act, regardless of whether the State had authorized those services.
- ❖ REQUEST – Amend Section 1905 of the Social Security Act to authorize I/T/Us to bill for new Qualified Indian Provider Services.
- ❖ RESULT – Not yet been introduced.



Medicaid Legislative Change – Priority #2: Fix the Four Walls Issue

- ❖ While the TTAG believes CMS has the authority to fix the “Four Walls” issue administratively, it has also prepared a legislative fix for the issue.
- ❖ REQUEST – Amend Section 1905(a)(9) of the Social Security Act to clarify that clinic services provided in any location by an Indian health care provider may be billed.
- ❖ RESULT – Congressional letter and TTAG request asking administration for more time to allow for a congressional fix.



Medicaid Legislative Change –

Priority #3: Extend 100 percent FMAP to Urban Indian Organizations Permanently

- ❖ Currently, CMS reimburses States for 100 percent of the cost of Medicaid services that are received through IHS and tribal providers (100 percent FMAP). Services received through Urban Indian health care providers currently qualify for 100 percent reimbursement, but only through March 31, 2023.
- ❖ REQUEST – Amend Section 1905 of the Social Security Act to authorize 100 percent FMAP for services received through Urban Indian Organizations on a permanent basis.
- ❖ RESULT – Legislation introduced by Rep. Raul Ruiz (D-CA): H.R. 1888 in the last Congress.



For More Information:
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