

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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Submitted via FederalRegister.gov

June 1, 2020

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

RE: Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC) – Tribal Recommendations and Requests

Dear Administrator Verma,

On behalf of the Tribal Technical Advisory Group (TTAG)¹ to the Centers for Medicare & Medicaid Services (CMS), I write to submit comments in response to the CMS interim final rule addressing a variety of payment and practice needs for patients and health care providers raised in response to the COVID-19 pandemic, including expanding telehealth practice and relaxing rules for teaching physicians' practice. TTAG makes the following recommendations, which pertain mainly to the increased telehealth flexibilities that have been provided in the rule.

I. Expansion of Telehealth

First of all, we want to acknowledge and thank the department for expanding the modalities through which telehealth can be delivered. In addition to reducing risk from COVID 19, telehealth expands care to those who may live hours from an Indian Health Service (IHS) or Tribal facility and for whom travel may be prohibitively difficult. We particularly appreciate the flexibility allowing the use of smart phones and similar devices to facilitate two-way audio/video communication. Although this change has been welcome and helpful, this measure does not go far enough in addressing the communication issues present in Indian Country.

Indian Country is largely rural and like many rural communities, Tribal communities face many issues with connectivity. Broadband internet and cellular phone service can be inconsistent or even unavailable in some places. In 2019, the Federal Communications Commission (FCC) released a report that found that issues of connectivity are even more severe for Indian Country, when compared with other rural communities. When compared to people who live on non-Tribal

¹ TTAG advises CMS on Indian health policy issues concerning Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and any other health care program funded in whole or in part by CMS. In particular, the TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives (AI/ANs) under these federal health care programs, including through providers operating in the Indian Health Service (IHS), Indian Tribes, Tribal organizations, and Urban Indian Organizations (collectively I/T/Us).

lands, both rural and urban, those who live on Tribal land are less likely to have access to broadband internet.² In order to address this disparity, we urge CMS to expanding the allowable modalities to include audio-only options, as they have already done for other services.

We strongly support CMS’s decision to cover a range of “telephone assessment and management services,” as well as the extended coverage for virtual check-ins and e-visits that do not ordinarily involve a face-to-face visit and thus do not qualify as telehealth services. As CMS noted in the IFR’s Preamble, such services have “become an important part of overall physician care of Medicaid beneficiaries.” These services are especially important during the current public health emergency and in the predominantly rural areas served by the IHS and Tribal organizations.

We also acknowledge and support the expansion of the use of two-way telephonic devices in the treatment of opioid addiction disorders. Given the severity of the opioid epidemic in Indian Country, this is a much needed expansion that will make this treatment more readily available and ensure continuity of treatment during the public health emergency.

We feel that the ability to use an audio-only device necessitates a further expansion. In many Tribal communities, cellular phone reception is unreliable and often times unavailable. People without cellular phone reception or internet often find themselves in a virtual “black hole” where they are not currently able to access any telehealth services. This creates a disruption in care and facilitates the worsening of health outcomes. We urge CMS to both extend the ability to receive service via an audio-only communication method to all forms of telehealth and to expand the definition of “audio only” device to include other devices used for real time communication, such as a two-way radio.

At the end of the public health emergency, we urge CMS to consider making these expansions, both what we have suggested and has already been enacted, permanent. Allowing for an expanded use of telehealth recognizes the everyday access to care barriers many Tribal communities face, and provides sustainable solutions that will improve healthcare access and bring about better health outcomes for Tribal people. It has long been recognized that the federal government has a trust responsibility to Tribal nations and taking advantage of the legally permissible mechanisms to expand telehealth to as many American Indian/Alaska Natives (AI/ANs) as possible would be a fulfillment of that responsibility.

II. Addressing Provider Shortages

We also support the decision to allow direct physician supervision of non-physician providers to be furnished via interactive telecommunications technology. Given that the Indian health system has struggled with provider shortages, the ability for non-physician providers to provide care under the supervision of a remote physician represents a substantial expansion of the capacity of Indian health providers to provide care. Many Indian health providers currently rely extensively on non-physician providers and the ability of physicians to remotely provide supervision is extremely helpful for expanding the capacity to provide needed care.

² See: *Report on Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018*, Federal Communications Commission, May 2019, <https://docs.fcc.gov/public/attachments/DOC-357269A1.pdf>

While remote supervision serves the immediate purpose of allowing non-physician providers to practice without having to be in the same room as their physician supervisors, it also provides a mechanism through which provider shortages may be addressed. The infrastructure to allow this change in practice will be built and cultivated during this expansion. However, the level of investment made (in needed technology and training) will largely depend on whether or not these beneficial changes have a good chance of being made permanent. We encourage you to use all available authorities to make this expansion permanent.

III. Providing for Higher Reimbursement Rates

We agree with CMS's conclusion in the IFR's preamble that "the relative resource costs of furnishing ... services via telehealth may not significantly differ from the resource costs involved when these services are furnished in person." While CMS has acknowledged that telehealth is no less expensive than a face to face encounter, their reimbursements to Indian health providers do not reflect this reality. The IFR provides that physicians are to be reimbursed at a rate that takes into account the increased expense of needed technology, a courtesy that has seemingly not been extended to Indian health providers.

IHS and Tribal outpatient hospitals, their provider-based clinics, and Grandfathered Tribal FQHCs should be paid at the same rate for their distant-site telehealth services as would apply had they furnished those services in person. Many Indian health providers have incurred a significant expense to build infrastructure for the rapid expansion of telehealth that has occurred during the public health emergency, adding an inflated price tag on the provision of this care. These providers also continue to employ the staff necessary to provide these services. The reality of the cost of these services is not reflected in the current reimbursement rates for telehealth services.

Currently, and we think incorrectly,³ there is wide disparity between the rates that CMS pays for in-person and telehealth services. In-person services covered under Part B, including physician services, are paid at the OMB/IHS All Inclusive Rate (AIR), currently \$479 per encounter for facilities in the lower-48 states and \$710 in Alaska.⁴ The AIR is a flat daily cost-based average rate that is established annually by CMS and IHS and approved by OMB, based upon a review of yearly cost reports prepared by IHS's contractor.⁵ The AIR reflects the cost of all services and supplies furnished by a Tribal facility to a patient in a single day, and are not adjusted for the complexity of the patient's health care needs, the length of the visit, or the number or type of practitioners involved in the patient's care. Tribal hospitals and their clinics, but not grandfathered Tribal FQHCs, also receive payment for their clinical staff's in-person professional services under

³ In our view, the payment differential lacks a sound statutory and policy basis and should be eliminated permanently, not just for the duration of the COVID-19 Public Health Emergency. We look forward to discussing a permanent change with CMS leadership through the CMS Tribal Technical Advisory Group or other appropriate forums.

⁴ AIRs are published annually in the federal register. The 2020 rates were published at 85 Fed. Reg. 21864 (April 20, 2020), <https://www.govinfo.gov/content/pkg/FR-2020-04-20/pdf/2020-08247.pdf>. The higher rate for Alaska facilities reflects their much higher operational costs.

⁵ CMS Medicare Claims Processing Manual Section (Publication 104), sec. 100.5.

the MPFS, on assignment by the clinical staff. For the same service furnished as telehealth, however, CMS currently pays only the assigned physician fee to the distant site Tribal hospital or provider-based clinic, and *nothing whatsoever for the facility's own associated costs* - a \$479 per visit differential for lower-48 Tribal facilities.⁶ Grandfathered Tribal FQHCs, which were not authorized to furnish distant site telehealth services at all before the PHE, are also paid far less for those services during the PHE than they would be for the same service furnished in person. An in-person service would be paid at the \$479 AIR, but a telehealth service will be at only \$92.03⁷. These extreme payment differentials push the cost of telehealth services onto Tribes and Tribal health programs that can ill afford them, effectively penalizing them for seeing patients remotely rather than in person. This has never been appropriate or sensible, and it is especially imprudent and dangerous at this time, when telehealth services should be encouraged in order to protect patients and providers alike and contain the spread of COVID-19.

We believe that CMS has the authority to rectify these disparities and make it retroactive to the beginning of the public health emergency. Under the status quo, Indian health providers are often providing telehealth to their financial detriment. Given the narrow margins under which many providers currently operate, this imperils the financial stability of the entire system and it is imperative that the agency revisit this issue and make these adjustments. We also recommend that these adjustments be made permanent, in recognition of the cost of telehealth and the lack of difference in costs between telehealth and face-to-face care.

IV. Conclusion

We recommend that CMS take into consideration the unique needs of the Indian health system and the population that it serves, as well as its unique obligations to Indian Country. This letter outlines the unique struggles that AI/ANs face when it comes to accessing telehealth through traditional two-way interactive communication tools, the need for expanding remote supervision to address provider shortages, and the need to address disparities in reimbursement rates. We hope that you will consider our suggestions and our recommendation that these changes be made permanent and available after the conclusion of the public health emergency.

Thank you in advance for consideration of our comments and recommendations.

Sincerely,



W. Ron Allen, Chair, Tribal Technical Advisory Group
Chair/CEO, Jamestown S'Klallam Tribe

⁶ The originating site is paid the same \$26.65 nominal originating site facility fee as for non-Tribal sites.

⁷ See CMS "MLN Matters" SE 20016, updated April 30, 2020, <https://www.cms.gov/files/document/se20016.pdf>. We recognizes that the rates was established under the CARES Act directive that the FQHC rate should be similar to the national average payment rate for comparable telehealth services furnished under the MPFS. Given their unique history and reimbursement methodology, however, that directive should not apply to Grandfathered Tribal FQHCs, which should instead be reimbursed for the service at the same AIR that applies for patients seen on site.