CMS TTAG Tribal Health Policy and Legislative Priorities

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TTAG Policy and Legislative Goals

- Increase third party resources through Medicare, Medicaid, CHIP and ACA reimbursement to Indian health care providers
- Increase access to coverage to American Indians and Alaska Natives through the 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

Health Equity Cannot Be Achieved without Policy and Legislative Change

- The Indian Health system is unique, and as a result Medicare/Medicaid/CHIP ACA law and policy need to be adapted from time to time in order to work for AI/ANs and Indian health care providers
- Because of the unique nature of the Indian health system, many of CMS and HHS's health equity initiatives will not work for Indian country.
- More targeted, Indian-specific legislative and policy change is needed.
- The CMS Tribal Technical Advisory Group developed a set of policy and legislative priorities in 2020 and has been working to get them implemented ever since

Policy or Legislative Change?

- Policy Changes:
  - A change in regulation or CMS policy that does not need legislation and can be achieved if CMS just agrees to change its policy
  - A change to sub-regulatory guidance (SMD or SHO letters), approving Indian specific SPAs and Waivers, issuing specific guidance on tribal issues.
- Legislative Changes:
  - A change that is contrary to statute and requires a legislative fix

Medicare Policy Change - Increase Medicare Reimbursement to Tribal Hospitals for COVID-19 Testing

- Novitas, the CMS MAC for IHS and tribal providers, initially only allowed IHS and tribal hospitals to be reimbursed a nominal dispensing fee for COVID 19 testing, even though they were doing the actual testing.
- REQUEST – To allows IHS and tribal hospitals to be reimbursed at the IHS OMB rates for COVID 19 testing.
- RESULT – CMS worked with Novitas to allow IHS and tribal hospitals to be reimbursed at the IHS OMB rates for COVID 19 testing.

Medicare Policy Change – Update Chapter 19 of Medicare Claims Processing Manual with Tribes

- Chapter 19 of the Medicare Claims Processing Manual provides Medicare billing and reimbursement guidance for IHS and tribal providers, but is out of date and full of internal inconsistencies
- CMS has been updating the Chapter for some time
- REQUEST – Create a tribal workgroup to assist CMS review and revise Chapter 19
- RESULT – CMS worked with the TTAG to review Chapter 19 to update it, but has not committed to considering any policy changes in the manual requested by Tribes.

Medicare Policy Change – 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 Policy Change – PBMs and Part D plans fully reimburse tribal pharmacies

- Pharmacy benefit managers and Part D plans 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 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 worked together to propose changes to the Part D Indian Addendum which are under review

Medicare Policy Change – Make the IHS OMB outpatient rate available to all Indian health programs that request it

- Currently, 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 and is trying to determine what input it would have on Medicare funding.

Medicare Policy Change – 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 Policy Change – 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 Policy Change – Issue Medicaid SHO Letter to Managed Care Organizations

- Indian health care provider continue to have difficulty being paid correctly by Medicaid Managed Care Organizations, and States often do not enforce the Indian Medicaid Managed Care protections in 42 C.F.R. 438.14.
- REQUEST – That CMS issues a State Health Official (SHO) letter to State Medicaid directors directing them to require the Managed Care Organizations comply with the Indian managed care protections as a condition of getting paid by the State, and requiring MCOs to deem all Indian health care providers to be in-network regards of whether they enter into a network provider agreement
- RESULT – CMS has discussed Medicaid Managed Care issues with tribes on a case by case basis but has not yet issued the requested SHO letter.

Medicaid Policy Change – 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 Policy Change – 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

Other Policy Change – Create an Indian Safe Harbor to the Anti-Kickback Law

- Since 2012, the TTAG has requested that the HHS Office of Inspector General (OIG) approve its request to create an Indian specific safe harbor to the Anti-Kickback Statute
- Federally Qualified Health Centers have their own safe harbor, but it is not broad enough to include all IHS and tribal health care providers, including hospitals
- The lack of a safe harbor chills legitimate efforts to coordinate care between different aspects of the Indian health system that would not result in any increased federal cost
- REQUEST – HHS OIG should approve the TTAG's request for an Indian-specific safe harbor
- RESULT – HHS OIG has not taken action on this request since 2012

Medicaid Legislative Change – 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
- 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 – 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 - Improving Access to Indian Health Services Act

Medicaid Legislative Change – 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 – Legislation introduced by Rep. Raul Ruiz (D-CA): H.R. 1888 - Improving Access to Indian Health Services Act. Hearings held in Energy and Commerce Committee on March 23, 2021.
- Also included in legislation introduced by Senator Cory Booker (D-NJ) - S. 4486 – the Health Equity and Accountability Act

Medicare Legislative Change – Ensure Parity in Reimbursement for Indian Health Care Providers

- 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.
- AI/AN have a pre-paid right to health care at no cost to themselves, so Indian health care providers routinely waive the 20 percent Medicare patient co-pay so that AI/AN patients are not charged for care
- This means that Indian health care providers only receive 80 percent of Medicare reimbursement
- 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 – 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 telehealth in a patient's home for example
- REQUEST – Approve the CONNECT Act or other legislation that would provide HHS the authority to waiver 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.

Medicare Legislative Change – Include new eligible provider types under Medicare for reimbursement to Indian health care providers

- 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 Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), Certified Community Health Aides and Practitioners (CHAPs), Behavioral Health Aides and Practitioners (BHAPs) and pharmacists.
- 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

Medicare Legislative Change – 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.

Medicare Legislative Change – Eliminate or Allow Direct Sponsorship of Part B Premiums by Indian health programs

- Medicare Part B provides important elder coverage for doctors and outpatient care, but it charges premiums.
- Unlike Medicaid, Medicare Part B does not exempt AI/AN from premiums
- Many AI/AN elders cannot afford the premiums, and as a result many tribal health programs "sponsor" (pay for) the premiums so that their elder beneficiaries can get Medicare Part B coverage
- States are allowed to pay for all the premiums they sponsor in one lump payment, but Tribal health programs are only allowed to reimburse individuals after they have paid the premiums up front.
- REQUEST – Eliminate Part B premiums for AI/AN enrollees or allow tribal health programs to directly sponsor Part B premiums for AI/AN Part B enrollees
- RESULT – CMS has informed the TTAG this would require a legislative fix

Medicare Legislative Change – Provide Relief from Medicare Part B Penalties to AI/AN Elders

- Medicare Part B imposes penalties for elders who delay enrollment once they are eligible. Penalties do not apply if an elder has coverage through insurance, but do apply if they are eligible for IHS.
- REQUEST – Deem access to IHS creditable coverage in order to exempt AI/AN elders from Medicare Part B penalties
- RESULT – CMS has informed the TTAG this would require a legislative fix

Medicare Legislative Change – 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 are
- RESULT – CMS has informed the TTAG this would require a legislative fix