**CMS TTAG Medicare (Legislative Fixes) Priorities**
**March 15, 2023**

**Medicare Priority #1: Part A – Eliminate Medicare Part B Premiums and Deductibles for IHS eligible people**

Medicare and Medicaid reimbursements are vital sources of funding for Indian health programs. Together they supplement the dramatically inadequate direct funding from IHS, and help fulfill the federal trust responsibility for Indian health. But while federal law exempts IHS beneficiaries from paying Medicaid premiums and other Medicaid cost sharing, there is no such exemption for Medicare. Consequently, Indian health programs can receive Part B reimbursement only if their eligible patients enroll in the program, and only if those patients either pay the monthly premium themselves or have it paid on their behalf by a sponsoring tribe, Indian health programs, or State Medicaid program. The "standard" Part B premium and deductible have been rising steadily over the years: for 2023 the premium stands at $164.90 per month for individuals earning $97,000 or less per year, with much higher premiums for those earning more, and annual deductibles will be $226. Most AI/AN elders cannot afford the standard premium, and even those who could have little incentive to pay it, given their right under the trust responsibility to receive no-charge care from the Indian health system. The Medicare Part B Premium thus presents a major obstacle to Medicare reimbursement for Indian health programs, a significant and growing cost for sponsoring tribes and Medicaid programs, and a breach of the federal trust responsibility for Indian health. Congress had it right when it waived Medicaid cost sharing for IHS beneficiaries, and there is no logical reason to treat AI/AN people enrolled in Medicare and associated premiums differently. Congress should exempt IHS beneficiaries from Medicare Part B premiums and deductibles.

**Medicare Priority #1: Part B – Ensure parity in Medicare reimbursement for Indian Health Care Providers (Cost-sharing)**

Chronic underfunding of IHS and Tribal facilities have resulted in significant economic disruption and loss of third-party revenues, including Medicare billing. The COVID-19 pandemic has exacerbated the fact that Indian health care providers are not fully reimbursed for the cost of providing Medicare covered services. Unlike other Medicare providers, Indian health care providers are not generally able to bill AI/AN Medicare patients and routinely must waive the 20 percent patient copay. This means that as a rule, Indian health care providers only receive 80 percent of reasonable charges, and are not paid the remaining 20 percent by their patients. As a result, IHS and Tribal facilities are only being paid 80 cents on the dollar for their Medicare services compared to other providers. This legislation is needed to ensure that the United States reimburses Indian health care providers in full for Medicare services they provide to AI/AN people, and to ensure that AI/AN People can seek services outside the Indian health system without having to face significant cost sharing burdens they may not be able to afford. The United States has a federal trust responsibility to provide health care for AI/ANs, and cost-sharing requirements are inconsistent with this obligation. Medicaid exempts AI/ANs from cost-sharing, and Medicare should do the same.

**Legislative Language (Part A and Part B):**

"(a) IN GENERAL. —Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended— by inserting before the period at the end the following:

‘‘, and (g) notwithstanding any provision of law,

(1) IN GENERAL. —No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this title.

(2) ) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—Payment due under this title to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under such title, shall be at 100 percent of the applicable rate and may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

(3) RULE OF CONSTRUCTION. —Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this title who is an Indian.''

**Medicare Priority #2 – Include Pharmacists Certified Community Health Aides and Practitioners (CHA/Ps), Behavioral Health Aides and Practitioners (BHA/P)s, and Dental Health Aide Therapists (DHATs) as eligible provider types under Medicare for reimbursement to IHS, Tribal health programs, and Urban Indian Organizations, for all Medicare-covered services that are within the scope of their licensed or certified practice under applicable State, federal, or tribal laws.**

The 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. This will go a long way towards addressing the severe shortage of healthcare professionals and workers in Indian Country and throughout the Indian healthcare system.

We now ask Congress to build on that important step, by also establishing coverage for several other non-physician practitioners whose services are of particular importance to Indian Healthcare programs and their AI/AN patients, including Pharmacists, CHA/Ps, BHA/Ps, and DHATs.

These practitioners all receive rigorous training that equips them to furnish many of the same services that physicians, MFTs, MHCs, and other Medicare-recognized professionals do, and like them, they are subject to strict licensing, certification, ethical, and continuing education requirements. CHA/Ps are trained to provide primary and emergency health care services, and they are the only healthcare providers in dozens of remote Alaska Native communities. Higher-level BHA/Ps are qualified to furnish many of the same behavioral health services that MFTs and MHCs do. Pharmacists are professionally trained to furnish a wide array of related healthcare services beyond merely filling and dispensing medications; they play a vital role in many Indian health programs delivering, among other services, clinic-based and protocol-driven anticoagulation, tobacco cessation, cardiovascular risk reduction, and asthma/COPD stabilization services, as well as medication-assisted treatment (MAT) for substance use disorders.

All these providers furnish essential, effective, and high-quality care that is covered by many Medicaid programs, and that Medicare covers when furnished by other provider types, yet Medicare does not

cover them, nor do the many non-governmental healthcare plans and health insurers that follow Medicare's lead. This deprives Indian Health programs of critically needed federal reimbursement for vital healthcare services to AI/ANs, needlessly straining the programs' already overtaxed resources and jeopardizing their ability to serve their patients. The failure to recognize and authorize Medicare payment for services furnished by these well-qualified providers perpetuates historic inequities experienced by AI/AN people, squanders the talents of these dedicated workers, and misses a meaningful opportunity to respond more fully to what the now nation-wide shortage of qualified health care workers. It is time for Congress to fully recognize the competency and capacity of these under-appreciated provider types, and to authorize Medicare reimbursement for all otherwise-covered Medicare services that they are qualified to furnish under applicable laws.

**Legislative Language:**

**Adding Medicare Part B coverage for services of Indian Health Program Pharmacist and Certified Community Health Practitioner Services.**

"Section 1861(s) of the Social Security Act [42 U.S.C. 1395x(s)] (Definition of "Medical and Other Health Services") is amended by adding a new subparagraph (JJ) as follows:

(JJ) Indian health program pharmacist and certified community practitioner services as defined in subsection (mmm).

--Section 1861of the Social Security Act [42 U.S.C. 1395x) (Definitions) is amended by adding at the end the following new subsections:
(mmm) "INDIAN HEALTH PROGRAM PHARMACIST AND CERTIFIED COMMUNITY PRACTITIONER SERVICES; INDIAN HEALTH PROGRAM PHARMACIST AND CERTIFIED COMMUNITY PRACTITIONER. --

(1)"Indian health program pharmacist and certified community practitioner services" means services furnished by or through the Indian Health Service, any Tribal Health Program (as defined in section 4 of the Indian Health Care Improvement Act [25 U.S.C. section 1603]), or any Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act) that would otherwise be covered if furnished by a physician or as an incident to a physician's service and that are furnished within the scope of licensure or certification by a licensed pharmacist or certified community practitioner.

(2) "Indian health program pharmacist" means any individual licensed and in good standing as a pharmacist in any State, who furnishes services within the scope of that licensure by or through the Indian Health Service, any Tribal Health Program (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. section 1603], or any Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act).

(3) Indian health program certified community practitioner" means any individual certified by and in good standing with a federally- or tribally-established Community Health Aide Program Certification Board, including but not limited to Community Health Aides and Practitioners, Behavioral Health Aides and Practitioners, and Dental Health Aide Therapists, , who furnishes services within the scope of that certification by or through the Indian Health Service, any Tribal Health Program (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. section 1603], or any Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act).

**Adding Medicare and Medicaid Coverage for Services furnished in Certain Setting by Pharmacists and Certified Community Health Practitioners working in Indian Health Programs.**

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS. —Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a mental health counselor (as defined in subsection (lll)(4))'' and inserting ", by a mental health counselor (as defined in subsection (III(4), or by an Indian health program pharmacist or Indian health program certified community practitioner (as defined in subsection (mmm)."

(2) HOSPICE PROGRAMS. —Section 1861(dd)(2)(B)(i)(III) of the Social Security Act (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by striking "or mental health counselor" and inserting '', mental health counselor, Indian health program pharmacist, or Indian health program certified community practitioner."

**Medicare Priority #3: Expand telehealth capacity and access in Indian Country by permanently extending waivers under Medicare for the use of telehealth and enacting certain sections of the CONNECT to Health Act**

During the COVID-19 crisis, telehealth and telemedicine have been especially critical to providing health care services to AI/AN people. Unfortunately, rural tribal nations may be unable to provide these services due to the restrictions on Medicare telehealth and the lack of broadband capacity or infrastructure in their area. COVID-19 has dramatically increased the need to connect Medicare patients to their providers through telehealth. This increased need is likely to continue after the national emergency has passed, particularly for patients in the Indian health system. In addition, as more AI/AN patients become accustomed over time to the telehealth model, it is likely to play a more significant role as a mechanism for delivering healthcare well beyond the end of this pandemic.

To this end, the Coronavirus Preparedness and Response Supplemental Appropriations Act provided the Secretary of HHS with the ability to waive telehealth restrictions during national emergencies. In doing so, it enacted Section 9 of the bipartisan Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019 (H.R. 4932, S. 2741). The CONNECT for Health Act was most recently introduced in 2021 (H.R. 2903, S. 1512) and has the support of the American Medical Association and over 100 other organizations.

Title IV, Subtitle B, Section 4113 of the Consolidated Appropriations Act, 2023 extends certain Medicare telehealth flexibilities through at least December 31, 2024. Among other things, these allow individuals to receive telehealth services in their home; allow telehealth services to be provided by qualified occupational therapists, qualified speech-language pathologists, and qualified audiologists; expand the telehealth services that may be furnished by federally qualified health centers (FQHCs) and rural health clinics (RHCs); suspends of requirements for initial and periodic in person visits for mental telehealth services; and authorize audio only telehealth services.

Section 101 of the CONNECT to Health Act of 2021 would provide HHS with the ability to waive certain telehealth restrictions outside of the national emergency context. These waivable restrictions include limitations on originating sites, provider types, technology, geographic area, services, and any other telehealth limitation. Section 107 would eliminate originating site requirements with respect to facilities operated by IHS, a Tribe or Tribal organization, or a Native Hawaiian health care system. Originating site requirements currently mandate that a patient be in a particular location such as a physician's office, hospital, or other specified clinical setting. These requirements prevent patients from being able to receive telehealth services in their homes, community centers, or other non-clinical locations. In addition, Sections 102–106, 108–109, and 303 of the CONNECT for Health Act affect use of telehealth

for emergency care, hospice care, RHCs and FQHCs; improve the process for adding services available via telehealth; remove geographic restrictions; allow waiver of restrictions during public health emergencies outside of the COVID-19 public health emergency; and expand the list of health professionals who may provide services through telehealth – all of which have immediate and long-term benefits to the Indian health system. With the urgent need to maximize telehealth flexibility in response to COVID-19 and beyond, tribal nations strongly recommend that Congress not only permanently extend the existing waiver authority for the use of telehealth under Medicare (Section 1834 of SSA), but to also enact certain sections of the CONNECT for Health Act.

CONNECT ACT - See Sections 101–109, and Section 303 of H.R. 2903 or S. 1512

**Legislative Language:**

**Sec. 101. Expanding the use of telehealth through the waiver of requirements**

(a) IN GENERAL.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(1) in paragraph (4)(C)(i), by striking "and (7)" and inserting "(7), and (9)"; and

(2) by adding at the end the following:

"(9) AUTHORITY TO WAIVE REQUIREMENTS AND LIMITATIONS.—

"(A) IN GENERAL.—Notwithstanding the preceding provisions of this subsection, in the case of telehealth services furnished on or after January 1, 2022, the Secretary may waive any requirement described in subparagraph (B) that is applicable to payment for telehealth services under this subsection, but only if the Secretary determines that such waiver would not adversely impact quality of care.

"(B) REQUIREMENTS DESCRIBED.—For purposes of this paragraph, requirements applicable to payment for telehealth services under this subsection are—

"(i) requirements relating to qualifications for an originating site under paragraph (4)(C)(ii);

"(ii) any geographic requirement under paragraph (4)(C)(i) (other than applicable State law requirements, including State licensure requirements);

"(iii) any limitation on the type of technology used to furnish telehealth services;

"(iv) any limitation on the types of practitioners who are eligible to furnish telehealth services (other than the requirement that the practitioner is enrolled under this title);

"(v) any limitation on specific services designated as telehealth services pursuant to this subsection (provided the Secretary determines that such services are clinically appropriate to furnish remotely); or

"(vi) any other limitation relating to the furnishing of telehealth services under this title identified by the Secretary.

"(C) WAIVER IMPLEMENTATION.—In implementing a waiver under this paragraph, the Secretary may establish parameters, as appropriate, for telehealth services under such waiver, including with respect to payment of a facility fee for originating sites and beneficiary and program integrity protections.

"(D) PUBLIC COMMENT.—The Secretary shall establish a process by which stakeholders may (on at least an annual basis) provide public comment on waivers under this paragraph.

"(E) PERIODIC REVIEW OF WAIVERS.—The Secretary shall periodically, but not more often than every 3 years, reassess each waiver under this paragraph to determine whether the waiver continues to meet the quality of care condition applicable under subparagraph (A). The Secretary shall terminate any waiver that does not continue to meet such condition.".

(b) POSTING OF INFORMATION.—Not later than 2 years after the date on which a waiver under section 1834(m)(9) of the Social Security Act, as added by subsection (a), first becomes effective, and at least every 2 years thereafter, the Secretary of Health and Human Services shall post on the Internet website of the Centers for Medicare & Medicaid Services—

(1) the number of Medicare beneficiaries receiving telehealth services by reason of each waiver under such section;

(2) the impact of such waivers on expenditures and utilization under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); and

(3) other outcomes, as determined appropriate by the Secretary.

**Sec. 102. Removing geographic requirements for telehealth services**

Section 1834(m)(4)(C) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)), as amended by section 101, is amended—

(1) in clause (i), in the matter preceding subclause (I), by inserting "and clause (iii)" after "and (9)"; and

(2) by adding at the end the following new clause:

> "(iii) REMOVAL OF GEOGRAPHIC REQUIREMENTS.—The geographic requirements described in clause (i) shall not apply with respect to telehealth services furnished on or after the date of the enactment of this clause.".

**Sec. 103. Expanding originating sites**

(a) EXPANDING THE HOME AS AN ORIGINATING SITE.—Section 1834(m)(4)(C)(ii)(X) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)(X)) is amended to read as follows:

"(X) (aa) Prior to the date of enactment of the CONNECT for Health Act of 2021, the home of an individual but only for purposes of section 1881(b)(3)(B) or telehealth services described in paragraph (7).

"(bb) On or after such date of enactment, the home of an individual.".

(b) ALLOWING ADDITIONAL ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclause:

"(XII) Any other site determined appropriate by the Secretary at which an eligible telehealth individual is located at the time a telehealth service is furnished via a telecommunications system.".

(c) PARAMETERS FOR NEW ORIGINATING SITES.—Section 1834(m)(4)(C) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)), as amended by section 102, is amended by adding at the end the following new clause:

"(iv) REQUIREMENTS FOR NEW SITES.—

"(I) IN GENERAL.—The Secretary may establish requirements for the furnishing of telehealth services at sites described in clause (ii)(XII) to provide for beneficiary and program integrity protections.

"(II) CLARIFICATION.—Nothing in this clause shall be construed to preclude the Secretary from establishing requirements for other originating sites described in clause (ii)".

(d) NO ORIGINATING SITE FACILITY FEE FOR NEW SITES.—Section 1834(m)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(2)(B)(ii)) is amended—

(1) in the heading, by striking "IF ORIGINATING SITE IS THE HOME" and inserting "FOR CERTAIN SITES"; and

(2) by striking "paragraph (4)(C)(ii)(X)" and inserting "subclause (X) or (XII) of paragraph (4)(C)".

**Sec. 104. Use of telehealth in emergency medical care**

(a) IN GENERAL.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), as amended by sections 101 and 102, is amended—

(1) in paragraph (4)(C)(i), by striking "and (9)" and inserting "(9), and (10)"; and

(2) by adding at the end the following:

"(10) TREATMENT OF EMERGENCY MEDICAL CARE FURNISHED THROUGH TELEHEALTH.—The geographic requirements described in paragraph (4)(C)(i) (other than applicable State law requirements, including State licensure requirements) shall not apply with respect to telehealth services that are services for emergency medical care (as determined by the Secretary) furnished on or after January 1, 2022, to an eligible telehealth individual.".

(b) ADDITIONAL SERVICES.—As part of the implementation of the amendments made by this section, the Secretary of Health and Human Services shall consider whether additional services should be added to the services specified in paragraph (4)(F)(i) of section 1834(m) of such Act (42 U.S.C. 1395m)) for authorized payment under paragraph (1) of such section.

**Sec. 105. Improvements to the process for adding telehealth services.**

(a) REVIEW.—The Secretary shall undertake a review of the process established pursuant to section 1834(m)(4)(F)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(F)(ii)), and based on the results of such review—

(1) implement revisions to the process so that the criteria to add services prioritizes, as appropriate, improved access to care through clinically appropriate telehealth services; and

(2) provide clarification on what requests to add telehealth services under such process should include.

(b) TEMPORARY COVERAGE OF CERTAIN TELEHEALTH SERVICES.—Section 1834(m)(4)(F) of the Social Security Act (42 U.S.C. 1395m(m)(4)(F)) is amended by adding at the end the following new clause:

"(iii) TEMPORARY COVERAGE OF CERTAIN TELEHEALTH SERVICES.—The Secretary may add services with a reasonable potential likelihood of clinical benefit and improved access to care when furnished via a telecommunications system (as determined by the Secretary) on a temporary basis to those specified in clause (i) for authorized payment under paragraph (1).".

**Sec. 106. Federally qualified health centers and rural health clinics.**

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), as amended by sections 101, 102, and 104, is amended—

(1) in paragraph (4)(C)(i), in the matter preceding subclause (I), by inserting ", (8)" after "(7)"; and

(2) in paragraph (8)—

(A) in the paragraph heading by inserting "AND AFTER" after "DURING";

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting "and after such emergency period" after "1135(g)(1)(B)";

(ii) in clause (ii), by striking "and" at the end;

(iii) by redesignating clause (iii) as clause (iv); and

(iv) by inserting after clause (ii) the following new clause:

"(iii) the geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to such a telehealth service; and"; and

(C) by striking subparagraph (B) and inserting the following:

"(B) PAYMENT.—

"(i) IN GENERAL.—A telehealth service furnished by a Federally qualified health center or a rural health clinic to an individual pursuant to this paragraph on or after the date of the enactment of this subparagraph shall be deemed to be so furnished to such individual as an outpatient of such clinic or facility (as applicable) for purposes of paragraph (1) or (3), respectively, of section 1861(aa) and payable as a Federally qualified health center service or rural health clinic service (as applicable) under the prospective payment system established under section 1834(o) or under section 1833(a)(3), respectively.

"(ii) TREATMENT OF COSTS FOR FQHC PPS CALCULATIONS AND RHC AIR CALCULATIONS.—Costs associated with the delivery of telehealth services by a Federally qualified health center or rural health clinic serving as a distant site pursuant to this paragraph shall be considered allowable costs for purposes of the prospective payment system established under section 1834(o) and any payment methodologies developed under section 1833(a)(3), as applicable.".

**Sec. 107. Native American health facilities.**

(a) IN GENERAL.—Section 1834(m)(4)(C) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)), as amended by sections 101, 102, and 103, is amended—

(1) in clause (i), by striking "clause (iii)" and inserting "clauses (iii) and (v)"; and

(2) by adding at the end the following new clause:

"(v) NATIVE AMERICAN HEALTH FACILITIES.—With respect to telehealth services furnished on or after January 1, 2022, the originating site requirements described in clauses (i) and (ii) shall not apply with respect to a facility of the Indian Health Service, whether operated by such Service, or by an Indian tribe (as that term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) or a tribal organization (as that term is defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), or a facility of the Native Hawaiian health care systems authorized under the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11701 et seq.).".

(b) NO ORIGINATING SITE FACILITY FEE FOR CERTAIN NATIVE AMERICAN FACILITIES.—Section 1834(m)(2)(B)(i) of the Social Security Act (42 U.S.C. 1395m(m)(2)(B)(i)) is amended, in the matter preceding subclause (I), by inserting "(other than an originating site that is only described in clause (v) of paragraph (4)(C), and does not meet the requirement for an originating site under clauses (i) and (ii) of such paragraph)" after "the originating site".

**Sec. 108. Waiver of telehealth requirements during public health emergencies.**

Section 1135(g)(1) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(2) by adding at the end the following new subparagraph:

"(C) EXCEPTION FOR WAIVER OF TELEHEALTH REQUIREMENTS DURING PUBLIC HEALTH EMERGENCIES.—For purposes of subsection (b)(8), in addition to the emergency period described in subparagraph (B), an 'emergency area' is a geographical area in which, and an 'emergency period' is the period during which, there exists a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.".

**Sec. 109. Use of telehealth in recertification for hospice care**

(a) IN GENERAL.—Section 1814(a)(7)(D)(i)(II) of the Social Security Act (42 U.S.C. 1395f(a)(7)(D)(i)(II)) is amended by inserting "and after such emergency period" after "1135(g)(1)(B)".

(b) GAO REPORT.—Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States shall submit a report to Congress evaluating the impact of the amendment made by subsection (a) on—

(1) the number and percentage of beneficiaries recertified for the Medicare hospice benefit at 180 days and for subsequent benefit periods;

(2) the appropriateness for hospice care of the patients recertified through the use of telehealth; and

(3) any other factors determined appropriate by the Comptroller General.

**Sec. 303. Model to allow additional health professionals to furnish telehealth services**

Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the end the following new clause:

"(xxviii) Allowing health professionals, such as those described in section 1819(b)(5)(G) or section 1861(ll)(4)(B), who are enrolled under section 1866(j) and not otherwise eligible under section 1834(m) to furnish telehealth services to furnish such services.".

**Medicare Priority #4: Exempt IHS Hospitals from Hospital Star Rating System**

The Hospital Compare rating system summarizes a variety of measures across seven areas of quality into a single star rating for each hospital. A hospital can get a rating between 1 and 5 stars, with a 5-star rating considered excellent. These ratings are meant to help consumers compare hospitals based on quality and performance measures. Star ratings are not calculated for Veterans Health Administration (VHA) or Department of Defense (DoD) hospitals.

A review of the Hospital Compare system reports that several IHS hospitals have a low star rating, with many IHS hospitals having no rating at all. The TTAG is concerned that the rating system does not adequately or fairly consider other federal reporting requirements that IHS facilities may have to comply

with or the population they serve. For example, our patient population includes higher proportions of patients with multiple complex chronic health conditions and lower socio-economic status, which both contribute to lower health status. If patients in the Indian Health System are in worse health than the average non-Indian, then the Hospital Star Ratings will likely be negatively impacted for hospitals serving AI/AN's. The star rating also has the potential to misinform consumers, and more importantly Congress, because the measures may not fairly consider the uniqueness of the Indian health system and the patients it serves.

The TTAG is concerned that the rating system unfairly measures IHS reported Medicare data in way that masks quality, over-emphasizes patient experiences, yet does not consider inadequate funding, and does not fairly consider the population being served. Because of this, the TTAG requests that Indian Health Service and Tribally-operated health facilities be exempt from the Hospital Compare system, consistent with other federal providers of care like the VHA and DoD.

**Legislative Language:**

**Medicare Priority #5: Ensure the Hospital Acquired Condition formula does not harm IHS/Tribal Hospitals (low-volume)**

The Hospital Acquired Condition (HAC) Reduction Program is a financial incentive program established under Section 3008 of the Affordable Care Act. It is for IPPS hospitals to improve patient safety by applying a one percent payment reduction to hospitals that rank in the lowest performing percentage of all subsection (d) hospitals with respect to the occurrence of hospital-acquired conditions (HACs) that appear during an applicable hospital stay. These HACs ae a group of reasonably-preventable conditions selected by CMS that patients did not have upon admission to a hospital, but which developed during the hospital stay.

The HAC program has three measures identified in the IPPS rule:

AHRQ Patient Safety Measures (Domain 1) weighted at 35%

- Patient safety indicators (PSI) PSI 90 composite measure (8 measures)

HAC Infections (Domain 2) is weighted at 65%

Payment adjustments will impact hospitals that rank among the lowest performing 25%.

The CDC formula that is utilized to calculate Standardized Infection Ratio (SIR) is: Divide the hospital's reported number of HAIs by a hospital's predicted number of HAIs. **A hospital's number of predicted HAIs must be greater than or equal to one in order to calculate an SIR.**

If a hospital has insufficient data (INS) which results in the CDC not calculating an SIR for this measure and does not calculate into the Doman 2 score or Total HAC score and results in the hospital having zero in Domain 2, Domain 1 is weighted at 100%, instead of 35%.

With national programs such as 'Target Zero,' 100,000 Lives, Campaign ZERO, etc. promoting and striving to reduce medical errors, hospital acquired conditions, etc. to zero it is unfortunate that a facility that achieves zero (0) hospital acquired infections would be removed from the Domain 2 weight.

The formula is erroneous in that it does not account or weight is not applied appropriately if your health facilities Domain 2 score is zero (0). Solutions would be to:

- Assign a score to a zero (0) rate, such as .0001, or
- Only apply the 35% weighted score to Domain 1, not the total of 100%

In 2015, Acting Administrator Andrew Slavitt wrote that CMS is working with CDC and others to evaluate an alternative analytic method that potentially could be used in the HAC Reduction program. Any changes to the scoring methodology would require CMS to do so through the rulemaking process.

Since then, numerous attempts have been made by TTAG and CMS staff to make accommodations for low-volume hospitals. However, these attempts have not accomplished the goal. The reason is that the formula developed by CDC is faulty and punishes low-volume hospitals. Congress should step in and require the CDC to revise its formula that more equitably accommodates the circumstances of Indian and other low-volume hospitals.

**Legislative Language:**

42 U.S.C. 1395ww(p)(2) is amended by adding the following at the end of subsection (2)(B)(ii):

In implementing this provision, the Secretary shall adapt its risk adjustment methodology so that low volume hospitals are able to have HAC infections weighted at 65 percent even if their predicted HAC infection rate is less than one.