

**CMS TTAG MEDICARE POLICY (REGULATORY/ADMINISTRATIVE) PRIORITY ISSUES**  
**March 15, 2023**

**Medicare Priority #1: Make the IHS Outpatient Encounter Rate Available to All Indian Outpatient Programs Who Request It**

For many years, the TTAG has been urging Medicare to allow all Indian outpatient programs the option to bill at the same IHS-established and OMB-approved encounter rates that would apply if the programs were directly operated by the IHS. Under current Medicare regulations and policies, programs operated by Tribes and Tribal Organizations under the Indian Self-Determination and Education Assistance Act may lose access to that rate, depending almost entirely on whether and when the program was last operated by the IHS or affiliated with an IHS operated hospital. Regardless of how similar or different they may otherwise be, Indian outpatient programs are now paid by Medicare at dramatically different rates, depending on whether they are operated by a Tribe or the IHS or qualify as a “provider-based facility,” a “grandfathered Tribal FQHC,” a non-grandfathered Tribal FQHC, or none of the above. In effect, Indian Tribes and Tribal Organizations are now financially penalized by the Medicare program for exercising their Indian Self-Determination Act rights, and their ability to provide a wide range of high-quality services to their AI/AN patients is compromised. CMS should adopt a new Medicare regulation, or amend its tribal provider-based and grandfathered tribal FQHC rules at 42 C.F.R. § 413.65(m) and 42 C.F.R. § 405.2462, to allow all Indian outpatient programs that request it to be paid for all Medicare-covered services at the IHS Outpatient encounter rate, and without irrelevant or additional cost-reporting requirements.

**Medicare Priority #2: Medicare Part D Reimbursement**

Tribal facilities across the country are getting hit with steep discounts in their reimbursements from pharmacy benefit managers (PBMs) based on tribes' ability to access drugs at discount rates under programs like the 340B program and VA prime vendor and due to Part D Direct and Indirect Remuneration (DIR) fees. PBMs are asking tribal facilities if they are accessing discounted pharmaceuticals, such as under the 340B program, and then discounting reimbursements based on the amount of the discount. PBMs are also reducing payments instead of passing along bonuses when they receive DIR fees. These efforts effectively take these benefits away from tribes and keeps them for the PBMs. Performance metrics being reported to CMS for IHS and Tribal facilities are also negatively affected, as PBMs inaccurately report low performance for medication adherence if the Part D program does not pay for the prescription. TTAG is developing a new Part D Addendum that would address these issues and request CMS to adopt same.

**Medicare Priority #3: Part A - Medicare Part C - Payment by Medicare Advantage Plans at OMB Rate**

Medicare Advantage plans are not reimbursing Indian health care providers at the IHS OMB rates, and often refusing to reimburse at all. CMS should require all MA plans to automatically deem Indian health care providers as in-network for reimbursement purposes, even if they do not enroll in a provider agreement. Section 206 of the IHCA (42 U.S.C. 1621e) gives Indian health care providers the right to recover their reasonable costs from certain third parties, including Medicare Advantage plans, regardless of whether they are in-network or not. As a cost-based rate, the IHS OMB rate at the very least should be considered "reasonable costs" for purposes of Section 206.

TTAG request CMS to develop and implement a Part C Indian Addendum.

**Medicare Priority #3: Part B - Part C Plans - Community Education to Prevent Predatory Medicare Advantage Enrollment Practices**

Some Medicare Advantage Plans have targeted Tribal members for plan enrollment, using predatory practices to entice them – and then not paying IHS and Tribal providers. Insurance companies meet with Tribal members, sometimes at Tribal senior citizen centers, to tout the benefits of enrolling in Medicare Advantage Plans. However, enrollment in the Medicare Advantage plans is disruptive to Indian Health Care providers. Most Indian Health Providers are not contracted providers under Medicare Advantage plans, and so the plans do not pay the IHS/Tribal facilities. In addition, Indian Health Care Providers not contracted to MA plans are unable to refer patients to the plan's specialty providers. Funding is needed for enrollment assistance to provide education for AI/ANs to help them understand how their services at I/T facilities would be impacted if they enroll into a Medicare Advantage plan. TTAG request CMS to develop FAQ's that clarify these issues and require usage by all Part C plans and brokers.

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

COVID-19 made it necessary for the Medicare program to cover more telehealth services to allow access to providers during the pandemic. But it has also demonstrated the general safety and effectiveness of telemedicine, and the extent to which, even in normal times, it can dramatically increase access to needed primary, specialty and behavioral health services, particularly in rural areas. 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. As a result, 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.

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 Priority #5: Exempt ITU 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." This is inconsistent with the right of Indian health care providers to limit services to IHS beneficiaries. We request an exemption from the competitive bidding process to allow Indian health care providers to access and bill for DME.