Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
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Submitted via FederalRegister.gov

June 7, 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-5531-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, which addressed 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. This letter will reiterate many of the points that we made in our comment on CMS-1744-IFC, which also expanded access to telehealth through the Medicare program. TTAG makes the following recommendations, which pertain mainly to the increased telehealth flexibilities that have been provided in the rule.

I. COVID-19 Testing

We want to express support for the expansion of access to Medicare reimbursement for COVID-19 testing, particularly the removal of the requirement that a patient have a referral from a treating physician or practitioner. We believe that the removal of this barrier will make it easier for Medicare beneficiaries to access testing and for Tribes to ensure that their citizens are tested so they can contain the spread of the disease across Tribal land.

[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).

II. Expansion of Telehealth

i. Originating Site

We also want to acknowledge and thank the department for expanding the locations from which telehealth can be received and reimbursed through Medicare. In addition to reducing risk from COVID 19, telehealth expands care for those who may live hours from an Indian Health Service (IHS) or Tribal facility and for whom travel may be prohibitively difficult. We appreciate that CMS has recognized this and allowed the home to be used as an originating site during the public health emergency (PHE). We also appreciate that CMS is allowing hospitals to still receive the originating site fee for services provided through their Hospital Outpatient Department (HOPD), even when the patient's originating site is in the home. We believe that this is a recognition of the continued support that is still needed from hospital staff to carry out these services and an attempt to ensure that providers are not providing them at a financial detriment.

We recognize that allowing the home to be used as an originating site is a deviation from traditional Medicare practices. Medicare has traditionally taken a more restrictive approach to the "originating site" issue, generally restricting it to locations in Health Provider Shortage Areas (HPSAs) and stipulating that it must be located within certain health care facilities[2]. The ability to receive care from the home has been an incredible step forward in recognizing the geographic limitations that many patients face when trying to receive services. However, we note that these expansions are due to sunset at the end of the PHE. We urge CMS to consider making this flexibility permanent. We believe that doing so would recognize the geographic realities of Indian Country. For example, even if a patient is located in a HPSA, they may still be far from a health care facility that would have previously been allowed to serve as an originating site. Distance is a barrier to access and CMS has demonstrated the ability to recognize this and make the applicable adjustments during the PHE. We believe that this should continue.

ii. Provider Types

We thank the department for their expansion of provider types that can provide services through telehealth, including allowing speech language pathologists, occupational therapists, and physical therapists to do so. We believe that this expansion will greatly reduce the need for patients to leave the home in order to receive these services. For many people, these services are essential to maintaining their quality of life and preparing them for their professional or personal future. We appreciate that the department has recognized their importance and allowed practitioners to provide these services to patients through telehealth, eliminating the need for patients to take unnecessary risks in order to receive them. We also believe that the facilitation of these services through telehealth ensures continuity of care so patients do not have to risk losing any progress that they have made through treatment.

We also recognize that this rule reiterates that CMS has opted to implement a sub-regulatory process to adding covered services. We believe that an expedited process for adding covered services will enable the Medicare program to be more responsive to the needs of patients by enabling them to more quickly move to add services. However, we believe that the already provided for expansions do not go far enough to ensure that American Indians and Alaska Natives

[2] The Health Resources and Services Administration (HRSA) provides a means for providers to see if they are eligible to serve as an originating site here: https://data.hrsa.gov/tools/medicare/telehealth

(AI/ANs) are able to receive the care that they need. We believe that the Medicare program should move to achieve parity with the flexibilities provided through the Medicaid program, which allows states to cover services provided through telehealth as long as they are reimbursed at the same rate as if they were provided in person. We believe that a similar reimbursement scheme would be beneficial for the Indian health system and strongly urge CMS to reimburse services provided through telehealth at the same rate as if they were provided face to face. We recognize the differences between Medicare and Medicaid, namely that states are partially responsible for paying for the services provided and that they are not mandated to cover telehealth services at all. However, many states have expanded telehealth through Medicaid for any service that is currently covered for face to face, as long as the provider thinks that it is clinically appropriate. We believe that Medicare should consider a similar approach and consider working with Congress to remove any statutory barriers that may exist to prevent this from happening.

iii. Audio Only Expansion

As mentioned before, 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 lands, both rural and urban, those who live on Tribal land are less likely to have access to broadband internet.[3] As we noted in our previous letter, 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. We believe that the example given in this IFC, of a person who may need to consult with a physician in order to adjust their medication in order to respond to a worsening condition, is a particularly apt example of how audio-only devices may be used during this emergency. We also want to acknowledge and support the agency's determination that these types of calls are not the only usage of telephonic telehealth. The agency's decision to update evaluation/management (E/M) codes to reflect the broad use of telephonic telehealth is much needed and we appreciate the recognition of the widespread usage of telephonic communication.

However, we believe 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.

[3] *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

III. Permanence of these Flexibilities

At the end of the PHE, 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. Many of these provisions have the potential to radically transform the ability of AI/ANs to access their health care system and the ability of the Indian health system to be reimbursed by Medicare for some of these extremely vital services.

To provide an example of where these flexibilities will be incredibly helpful, the ability to use audio-only communication is an incredible benefit for patients who are in geographically isolated communities and receiving care for chronic illnesses and behavioral health conditions, which often require routine monitoring from a practitioner. The lack of broadband infrastructure in many rural Tribal communities makes access to real-time audio/visual communication prohibitively difficult and makes them increasingly reliant on audio communication. The preservation and further expansion of audio only flexibilities will be incredibly important for ensuring access to health care for those who are in more geographically isolated communities. We strongly urge you to make these flexibilities permanent.

We also want to emphasize the importance of preserving originating site flexibilities, especially the ability to be seen from the home. For many in Indian Country, transportation is a substantial barrier. Given the rurality of many Tribal communities, AI/ANs often do not have access to public transportation and, owing to the disproportionate numbers of AI/ANs who are experiencing poverty, may not even have reliable personal transportation. The flexibilities provided during the PHE have shown us that it is possible to acknowledge these limitations and expand access through the regulatory process. We urge CMS to eliminate the sunset clause for the originate site changes and make them permanent. We believe that making these changes permanent would be a recognition of the struggles faced by AI/ANs when they attempt to access health care in their home communities. The ability to receive services from your home is an elimination of a substantial barrier to access.

We recognize that CMS is limited in what they can do by Section 1834(m) of the Social Security Act, which sets statutory restrictions on what is reimbursable through telehealth. We believe that CMS should work with Congress to make the necessary changes in order to make these flexibilities permanent.

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.

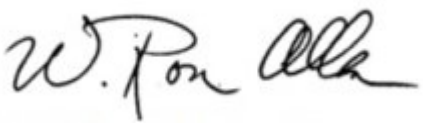
IV. Conclusion

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 importance of expanding originating site flexibilities, and the need to further expand the range of providers that can be reimbursed through Medicare. In order to recognize the role that telehealth plays in addressing the barriers faced by AI/ANs in accessing health care, we also urge CMS to reimburse for telehealth at the same rate as a face to face encounter. 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
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