

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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October 5, 2020

Submitted via regulations.gov

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: CMS-1734-P “Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2021.”

Dear Administrator Verma:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to provide a response to the Centers for Medicare and Medicaid Services (CMS) proposed rule, “Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2021,” listed as CMS-1734-P. We are particularly interested in the telehealth portions of this rule and how it impacts Indian health providers. We want to thank the agency for providing these flexibilities through the Medicare program for Tribal providers, they have allowed for an unprecedented expansion of telehealth in Indian Country. However, we feel that there are some additional improvements that the agency could make in order to make these flexibilities work better for Indian health providers.

First of all, the TTAG continues to advocate for the expansion of audio-only telehealth, including an expansion of the ability to provide direct supervision via audio-only telehealth. Much of Indian Country is rural, and as such, many Tribal citizens do not have access to broadband, which would allow them to take advantage of two-way real time audio/video communication. We believe that the failure to allow audio-only telehealth will result in a significant portion of Indian Country not being able to access telehealth. Given the rurality of Indian Country, telehealth plays a key role in bridging distance gaps between provider and patient. To this end, we also believe that any restrictions on number of allowable telehealth visits needs to be lifted so we can fully eliminate any distance barriers.

We also have concerns about reimbursement rates for telehealth and believe that it should have complete parity with in-person visits. The costs of care do not decline when it is offered via telehealth, providers still have to provide the same facilities and staffing in order to provide the service. However, the disparity in reimbursement rates fail to recognize this reality. We believe that this should be corrected.

Trust Responsibility

The United States owes a special duty of care to Tribal Nations, which animates and shapes every aspect of the federal government’s trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government’s unique responsibilities to Tribal

Nations has been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.¹ In 1977, the Senate report of the American Indian Policy Review Commission stated that, “[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people.” This trust responsibility is highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

Importantly, the Federal Government has a unique legal and political government to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals’ relationship to Tribal governments.²

The trust responsibility establishes a clear relationship between the Tribes and the federal government.³ The existence of this truly unique obligation supplies the legal justification and foundation for distinct health policy and regulatory making when dealing with American Indians and Alaska Natives (AI/ANs) and the Indian health system that provides their care. The federal government is responsible for ensuring the health of the Indian health system and its ability to provide health care to AI/ANs. We believe that ensuring that Indian health providers are able to take full advantage of emerging technologies, such as telehealth, to provide care to their patients is within the scope of the responsibility that the federal government owes Tribal Nations.

The Importance of Telehealth

The rapid expansion of telehealth has represented a paradigm shift in health care delivery. The expansion, facilitated by waivers from CMS and made into a necessity because of the COVID-19 pandemic, has increased the ability of Indian health providers to reach patients and provide them care from practically any location. For many of our patients, this has helped to ensure continuity of care and facilitate increased appointment attendance. It also allows a person to receive care in an environment where they are comfortable, whether it is in the home or through the usage of a local clinic as an originating site. Telehealth has provided a wealth of flexibility for both providers and patients.

As mentioned earlier, much of Indian Country is rural. In fact, 46.1% of AI/ANs live in rural communities, a rate which is over two and a half times the percentage of the rest of the population.⁴ Further, AI/ANs are 1.7% of the rural population, which is over two times higher than their 0.8% of the total population.⁵ The rural nature of the AI/AN population makes the adoption of technologies that bridge the distance gap between patient and provider essential.

¹ The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. See Seminole Nation v. United States, 316 U.S. 286 (1942), United States v. Mitchell, 463 U.S. 206, 225 (1983), and United States v. Navajo Nation, 537 U.S. 488 (2003).

² Introduction, “Cross-Agency Collaborations”, <https://www.hhs.gov/about/strategic-plan/introduction/index.html>

³ In Worcester v. Georgia, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third party actors.

⁴ Janice C. Probst, Fozia Ajmal, “Social Determinants of Health among Rural American Indian and Alaska Native Populations,” Univ. of S.C. Rural and Minority Health Research Center, July 2019 https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/socialdeterminantsofhealthamongruralamericanindianandalaskanativepopulations.pdf

⁵ *Id.*

We are interested in working with CMS to capture data on telehealth's success so we are better able to quantify its impact across Indian Country. We would like CMS to work with us to access Medicaid and Medicare data around the system so we can know what has worked, what has not worked, and what we can do to improve our outreach efforts in the future. It will also help our providers better understand local and national trends. Is a certain service disproportionately used at their facility when compared to others? The expansion of telehealth on such a wide scale is still new for many of our providers and we would benefit from accessing data so providers are better able to make decisions.

Reimbursement Limitations and Concerns

The TTAG urges CMS to consider adjusting the reimbursement rates for Medicare telehealth services. For Indian health care providers in particular, Medicare reimbursement rates for telehealth are dramatically less than for the same health care service delivered in person. While telehealth has become much more prevalent during the public health emergency and provides greater access to care for AI/ANs, it must be financially sustainable in order to continue to be a growing component of our healthcare systems. Telehealth reimbursement must be on par with reimbursement for the same service provided face-to-face, to ensure the permanence and advancement of the practice. We urge CMS to ensure IHS and Tribal hospitals performing COVID-19 laboratory tests are eligible for reimbursement at the encounter rate (OMB rate) since the facility continues to bear the same costs for collection, processing, analyzing, handling and follow-up on the results. The costs incurred by our healthcare systems remain the same, even when extending telehealth as an option for our patients. We continue to employ providers, nurses, support staff, business office staff and the like to perform telehealth. We also continue to pay all fixed costs of facilities and associated costs such as insurance and utilities, regardless if the service is delivered via telehealth. Parity in reimbursement must be reached between telehealth services and comparable face-to-face services in order for this initiative to be successful.

Direct Supervision

The TTAG welcomes the proposed rule's extension of flexibilities regarding remote and delegated supervision. These flexibilities are critical to the ability of Tribal health programs to provide access to care to patients in remote areas and areas where providers are scarce.

The proposed rule would continue allowing direct supervision by a provider using interactive audio/video technology through December 31, 2021.⁶ We strongly support this proposal, as the ability for the billing practitioner to supervise services remotely has been essential to allowing Tribal health programs to serve patients even when a practitioner is not available in the same location. This is important not only for reducing COVID-19 exposure during the Public Health Emergency (PHE), but also for ensuring that patients in areas with provider shortages have access to care. We recommend that CMS consider extending this flexibility beyond December 31, 2021 for Tribal health programs, many of which already struggle to connect patients with providers. Additionally, we request that CMS allow audio-only supervision to accommodate the lack of adequate broadband access and other technological barriers common in Indian Country. We

⁶ *Id.* at 50115.

further support the proposal to make permanent the ability of physical therapists and occupational therapists to delegate the provision of maintenance therapy services to a therapy assistant.⁷

The proposed rule would also extend flexibilities regarding diagnostic tests that have allowed Tribal health programs to increase their ability to properly diagnose patients and get them on the correct course of treatment. We support the proposed rule's extension of billing flexibilities for COVID-19 testing even when a provider does not also furnish a higher level evaluation and management service to the patient on the same day.⁸ We recommend that these flexibilities be permanently extended after the COVID-19 PHE ends, as the need for such testing will continue long after an emergency concludes. We also support the proposal to make permanent allowing supervision of certain diagnostic tests by nurse practitioners, clinical nurse specialists, physician assistants, and certified nurse-midwives when those providers are complying with requirements regarding relationships with supervising or collaborating physicians.⁹

Frequency of Telehealth Visits

During the PHE, CMS waived the requirement that providers perform in-person initial visits for nursing home residents. The proposed rule considers making this flexibility permanent, which TTAG endorses. Additionally, the TTAG supports eliminating the 30-day frequency limitation on nursing facility visits via telehealth. Tribal nursing homes are often in remote areas with provider shortages, and telehealth visits, including initial nursing home visits, provide flexibility that is important to ensuring access to care for our elders.

Expanded Coverage

The TTAG supports adding the nine series codes to the permanent list of Medicare telehealth services. We also are glad to see a slate of services in the Category III codes that would be temporarily allowable telehealth services through the end of the period of these flexibilities. Given the current reality of care delivery during the pandemic, particularly for elders, having the ability to reach patients where they are, in their homes, is crucial for the continued safety of vulnerable populations.

These telehealth service additions are an important first step, but they do not go far enough. We believe that services being proposed for temporary coverage could be added to the permanent list. In particular, many behavioral health related codes are proposed to be added only on a temporary basis. While the COVID-19 pandemic has exacerbated the problem, particularly for isolated elders, the United States' behavioral and mental health care system was under-supported even before the pandemic struck; and in Indian Country, access to behavioral health services has been extremely difficult or impossible, due to a lack of providers in communities. We request that CMS add more behavioral health services to the permanent list of services allowable for delivery via telehealth, to the maximum extent allowable under statute. This will allow providers to expand their ability to deliver behavioral health services with limited numbers of providers currently available, and will

⁷ *Id.* at 50147.

⁸ *Id.*

⁹ *Id.* at 50146.

increase access to these services for elder patients on a longer-term basis dealing with issues of isolation, substance use disorders, etc.

For the duration of the PHE, CMS previously established a separate Medicare payment for audio-only telephone evaluation and management services. In the proposed rule, CMS seeks comment on whether to develop coding and payment for a similar service to virtual check-ins that would be for a longer unit of time and a higher value.¹⁰ It also seeks comment on whether a separate payment for telephone-only services should be a provisional policy to remain in effect for a defined period of time after the end of the PHE or whether it should be added permanently.¹¹

While adding services to those allowable for delivery via telehealth helps expand coverage, the method through which telehealth is delivered is also an important way to expand access to health care. CMS's allowance of opioid treatment programs (OTPs) to provide telehealth through two-way, audio-only telephonic technology during the PHE is a welcome flexibility, but we think looking into the near future, delivery of these services via telehealth will need to continue for a longer period. Further, in some remote parts of the country like Alaska, services should be covered when furnished using audio-only telephone and two-way radio communication. While much of the urban United States enjoys broad availability of Wi-Fi and broadband services, the connectivity and access to these telecommunications services in rural America is unreliable at best. Indian Country occupies some of the most rural and remote parts of the country, and delivering services via video and audio telehealth is not always feasible. We request the CMS in its final rule expand the ability to provide all telehealth services via audio-only telephonic and two-way radio communication methods, to accommodate communities that lack access to the more advanced methods of audio and video real-time communications.

The TTAG also strongly supports the creation of a longer virtual check-in that would be reimbursed at a higher value. There is a significant need for elders to have the ability to connect remotely with practitioners in order to determine whether an in-person visit is necessary. Additionally, a higher reimbursement rate is needed because Tribal health programs continue to have significant facility and administrative costs associated with virtual check-ins.

Conclusion

The TTAG thanks the agency for the telehealth flexibilities that have been provided thus far, and hopes CMS will consider the many opportunities for improvement discussed in our comments. For example, the agency must expand the ability to provide telehealth and facilitate supervision through audio only modalities. We also believe that audio-only telehealth should be offered more broadly. Indian Country is predominantly rural and as telehealth continues to expand, requiring two-way audio/visual communication may result in us being left behind. We also need to see greater parity between in person and telehealth visits, especially given that the level of service offered does not change depending on the modality used. Finally, we would like to see restrictions lifted on frequency of telehealth visits. As mentioned before, many of our patients live in rural areas and telehealth is a bridge that helps to alleviate some of the distance based concerns. Thank

¹⁰ *Id.* at 50113.

¹¹ *Id.*

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you in advance for your considerations of our comments and we look forward to hearing back from the agency.

Sincerely,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is written in a cursive style with a large, sweeping initial "W" and a long, horizontal flourish at the end.

W. Ron Allen, CMS/TTAG Chairman
Chair/CEO, Jamestown S'Klallam Tribe