

# Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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September 13, 2021

The Honorable Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8013  
Baltimore, MD 21244-1850

**Re: CMS-1751-P “Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2022.”**

Dear Administrator Brooks-LaSure:

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 2022,” listed as CMS-1751-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 are concerned that the agency has decided not to add more services to the Medicare telehealth list for CY 2022. We encourage the agency to work with Tribes to foster the growth of telehealth services.

The TTAG also continues to advocate for the expansion of audio-only telehealth, including the ability to provide direct supervision via audio-only telehealth. Much of Indian Country is rural. 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 acknowledge and thank the agency for the limited expansion of audio-only that the rule provides. However, we feel that this is not enough and that the agency must further expand audio-only telehealth. We believe that the failure to expand audio-only telehealth will result in a significant portion of Indian Country unable to access telehealth. Given the rural nature of much of Indian Country, telehealth plays a crucial role in bridging geographic gaps between provider and patient. To this end, we also believe the agency must lift any restrictions on allowable telehealth visits to eliminate any distance barriers.

We also want to ensure that Indian health providers are reimbursed fairly for the services provided and invite CMS to consult with Tribes on this matter. We believe that CMS should pay Indian health providers in a way that allows them to provide vaccinations without diverting services from other elements of patient care. Further, we are also responding to the request for information from TTAG regarding reimbursement at the All-Inclusive Rate (AIR) for Indian Health Service (IHS) and Tribal facilities.

## **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.<sup>1</sup> 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.<sup>2</sup>

The trust responsibility establishes a clear relationship between the Tribes and the federal government.<sup>3</sup> The existence of this truly unique obligation supplies the legal justification and foundation for distinct health policy and regulations 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 viability 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 ensure continuity of care and facilitate increased appointment attendance. It also allows a person to receive care in an environment where they are physically and emotionally comfortable, whether 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. 46.1% of AI/ANs live in rural communities, a rate over two and a half times the percentage of the rest of the population.<sup>4</sup> Further, AI/ANs are

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<sup>1</sup> 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).

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

<sup>3</sup> 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.

<sup>4</sup> 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](https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/socialdeterminantsofhealthamongruralamericanindianandalaskanativepopulations.pdf)

1.7% of the rural population, over two times higher than their 0.8% representation in the total population.<sup>5</sup> The rural nature of the AI/AN population makes the adoption of technologies that bridge the distance gap between patient and provider essential.

Indian health advocates have long urged expanding access to telehealth in Indian Country, including expanding the services permitted and technologies allowed under the Medicare telehealth benefit as well as other communications-based technology services reimbursed by Medicare. Many Indian health care programs routinely struggle to provide services to patients who are in rural and extremely remote locations, lack access to transportation services, and face other medical, mental health, and socio-economic barriers to being able to access in-person services.

The COVID-19 pandemic demonstrated that expanding telemedicine is not only possible, but that it is a safe, reliable, and sustainable way to expand access to care for many AI/ANs. TTAG welcomed the telehealth and communications-based technology flexibilities that CMS implemented to respond to the COVID-19 public health emergency. We lament, however, that such flexibilities were not in place prior to the pandemic, which could have reduced many of the health disparities and vulnerabilities that allowed our communities to be disproportionately devastated by COVID-19.

TTAG urges CMS to expand telehealth flexibilities for Indian health programs to the maximum extent permitted under law, and to join us in advocating for the removal of statutory barriers that block AI/ANs from access to care.

#### Telehealth Services

TTAG supports CMS's proposal to retain all Medicare telehealth services added on a Category 3 basis through the end of CY 2023. We believe that this will help provide additional time to collect data to support the permanent inclusion of these services.

We are concerned that CMS has not recommended any services for addition to the Medicare telehealth list for CY 2022. We encourage CMS to work proactively with Indian health care programs and providers to facilitate the adoption of additional Medicare telehealth services in the future. Given CMS's treaty and trust responsibilities to Tribes, the burden should not be placed on already under-resourced Indian health programs to collect the information and data needed to support expansion of telehealth services.

#### Rural Emergency Hospitals

TTAG welcomes the inclusion of Rural Emergency Hospitals (REHs) as originating sites for Medicare telehealth purposes, as required by the Consolidated Appropriations Act, 2021 (CAA). We note that some Tribal facilities will not qualify to transition to REHs because they are not currently Critical Access Hospitals (CAHs) or qualifying subsection (d) hospitals. Yet communities without an existing CAH or qualifying subsection (d) hospital may be those most in need of an REH. We encourage CMS to work with Tribes and Congress to expand the availability of REHs throughout Indian Country.

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<sup>5</sup> *Id.*

Mental Health Services

TTAG strongly supports the expansion of mental health services via telehealth, as many in AI/AN communities lack the ability to meet with providers regularly in-person. Our communities, which are plagued by the effects of historical trauma due to U.S. colonization, suffer disproportionately from mental health issues, which manifest in increased rates of suicide, substance abuse, and poor physical health in our communities. In an attempt to respond to these significant health disparities, the Indian health system has been working to increase access to behavioral health services via telehealth during the pandemic and also post-pandemic. The proposed changes in this section of the proposed rule are very important due to the way they would impact the Indian health system.

As required by the CAA, CMS's proposed rule removes geographic restrictions on telehealth for mental health services, allowing patients to receive service in their homes. Section 123(a)(3) of the CAA required that a mental health patient have an in-person visit within six months before beginning treatment via telehealth, for services paid under the Physician Fee Schedule. This in-person visit requirement is not contained anywhere else in the Social Security Act for telehealth services, nor does it apply to tele-mental health services when the patient is located at a qualifying originating site. Further, as CMS notes in the proposed rule's preamble, for tele-mental health services furnished by RHCs and FQHCs, there is no statutory in-person visit requirement. CMS has asked for public comment whether it should nonetheless impose the same in-person visit requirement on RHCs and FQHCs as on providers paid under the PFS, or whether this would be excessive for those safety-net providers and the disadvantaged patients they serve, especially in rural areas.<sup>6</sup>

The TTAG recognizes that, with respect to initial services furnished by PFS providers, CMS is implementing a statutory requirement. However we are concerned that there is no clinical evidence for this arbitrary in-person requirement before a patient can access telehealth services.<sup>7</sup> We ask CMS to clarify that the statutory requirement applies only to services paid under the Physician Fee Schedule, and to refrain from imposing any similar requirement on providers paid under different methodologies, including FQHCs, RHS, and Indian health programs that are reimbursed at the Indian Health Service All-Inclusive Rate. We also encourage CMS to work with Congress to address this inappropriate requirement for PFS-billed services.

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<sup>6</sup> Proposed Rule Section III.B.1.c (“Additionally, we note that section 123 of the CAA also requires that there be an in-person service within 6 months prior to the furnishing of the telehealth service and at intervals thereafter as specified by the Secretary for mental health services furnished via Medicare telehealth under the PFS. We are seeking comment on whether we should consider a similar requirement for mental health services furnished by RHCs and FQHCs via telecommunications technology, or whether this requirement may be especially burdensome for beneficiaries receiving treatment at RHCs and FQHCs, particularly in rural areas. If we were to establish a similar requirement for RHC and FQHC mental health services, we could consider the proposal for Medicare telehealth services described in section II.D. of this proposed rule that there be an in-person service within 6 months prior to the furnishing of the telecommunications service and that an in-person service (without the use of telecommunications technology) be provided at least every 6 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders, which would be documented in the patient’s medical record, or whether we should defer to the clinical judgment of the practitioner on how often an in[1]person visit would be appropriate.”)

<sup>7</sup> <https://www.americantelemed.org/wp-content/uploads/2021/06/ATA-Overview-of-In-Person-Requirements-1.pdf>.

For services paid under the Physician Fee Schedule, the proposed rule would also require an in-person visit, not only within the “6-month period prior to the first time” the provider furnishes telehealth to the individual, as stated by law, but also within 6 months prior to subsequent telehealth visits. This effectively creates a new, arbitrary requirement for the patient to have an in-person mental health visit every 6 months should the patient plan to seek telehealth services with that provider. We note this is not required by the authorizing statute, which gives the Secretary of Health and Human Services (HHS) discretion to determine how frequently HHS in-person visits would be required after that.

The TTAG urges CMS to use its given regulatory authority and establish that no additional in-person visits are required for any provider to furnish telehealth services to an eligible Medicare beneficiary. At the very least, we ask that CMS refrain from imposing such a requirement on Indian health programs, RHCs, and FQHCs, all of which provide essential safety-net services to disadvantaged populations, often in rural and remote locations.<sup>8</sup> In many rural AI/AN communities, in-person visits are an enormous hurdle. Distances are far, transportation costs are prohibitive, and often there are challenges taking off from work or finding care for children and elders in order to travel to appointments. Further, mental health issues alone can make it difficult for patients to summon the ability to overcome all of those hurdles in order to seek the care they need. Cutting such patients off from mental health care threatens their wellbeing and their lives, as well as the wellbeing of those around them. We urge CMS to provide that, for Indian health care programs, follow-up visits are required as determined necessary by the provider.

#### Audio-Only Flexibilities

CMS’s proposed rule would revise the regulatory definition of “interactive telecommunications systems,” which are required to deliver telehealth services. This definition includes audio-only technology for diagnosing, evaluating, and treating mental health disorders when furnished to established patients and when the originating site is the patient’s home. CMS also proposes to allow Opioid Treatment Programs (OTPs) to provide audio-only counseling and therapy services.

These audio-only services would be available only when the patient or beneficiary is not able or willing to engage in two-way audio-visual telehealth interaction. The provider must be capable of and willing to engage in two-way audio-visual interaction.

TTAG welcomes the expansion of audio-only services, which we have long advocated for, but we encourage CMS to remove the requirement that providers of mental health or OTP services have audio-visual capability. In rural and underfunded Indian health care programs, providers sometimes lack the ability to provide audio-visual interactions, such as because of poor internet connectivity. In such situations, patients still need access to mental health and OTP counseling and therapy services, and these services can be delivered effectively over the phone or over a two-way radio.

For example, in rural Alaska, telephonic, audio-only access has made a world of difference during the pandemic. Over the course of the pandemic, one provider saw their substance use support group go from 10 participants to 60 participants, thanks to the availability of audio-only access to

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<sup>8</sup> Although some do not enroll as such, outpatient programs operated by Tribes and Tribal Organizations under the Indian Self-Determination and Education Assistance Act are included in the definition of FQHCs.

participate. That was an 800% increase in just that one service availability thanks to audio-only access. In addition, in some regions of Alaska providers report a steep drop in completed suicides, which is tremendous in a state with such high and increasing suicide rates. In one region of the State, during the pandemic, there have only been two completed suicide attempts. The year before the pandemic, that same region had as many as 14 completed suicide attempts.

Additionally, TTAG urges CMS to authorize audio-only services beyond mental health and OTP counseling and therapy services. Limiting audio-only services in this way limits many Indian health programs' ability to provide services via telehealth, leaving our programs and patients behind. Indian health programs can safely and effectively deliver a wide variety of telehealth services via audio-only communications.

We encourage CMS to take into account barriers to telecommunications infrastructure in Indian Country, including among providers, in determining what technology CMS deems necessary to provide critically needed services. Without such consideration, the digital divide in Indian Country will continue to widen the health disparities that plague our peoples.

### **Direct Supervision**

CMS's proposed rule seeks information on whether direct supervision requirements should be allowed to be met through virtual presence beyond the end of the COVID-19 public health emergency and, if so, whether such flexibilities should be permanent.

TTAG strongly recommends that CMS allow direct supervision requirements to be met through virtual presence on a permanent basis. This flexibility expands the availability of practitioners for our patients, which is desperately needed given the extreme provider shortages in the Indian health system. For a variety of reasons, including underfunding and remote locations, Indian health programs have difficulty recruiting and retaining providers, leaving our patients without access to the care they need. Direct supervision through virtual presence provides us with a tool to help work around this provider shortage, and it should be authorized on a permanent basis for Indian health programs.

### **Vaccine Administration Services**

CMS's proposed rule solicits comments regarding Medicare payment rates for the administration of certain preventative vaccines. In particular CMS is interested in the types of providers who furnish vaccines, how costs of COVID-19 vaccine administration compares with administration of other preventative vaccines, and how the pandemic has impacted costs and whether increased costs are expected to continue.

TTAG requests that CMS formally consult with Tribe regarding vaccine administration and its associated costs. The proposed rule solicits comments on whether vaccine administration should be reimbursed at the same rate as COVID-19 vaccine administration which is currently reimbursed at \$40 a dose. Indian health programs need to be paid sustainable rates for vaccine administration in order to provide vaccines without having to divert funding from other forms of patient care. As you know, CMS recently clarified that Indian health care providers should be reimbursed at the IHS OMB rates for COVID-19 testing. We believe that Indian health care providers should be reimbursed at the same rate for vaccinations. In the alternative, at the very least Indian health care

providers should be reimbursed at the same rate for non-COVID related vaccinations as they are for COVID vaccinations.

**All-Inclusive Rate Request for Information**

The TTAG would also like to respond to the request for information regarding giving the All-Inclusive Rate to all facilities run by the Indian Health Service (IHS) and Tribes. While we appreciate your response to our request, we believe that these questions fail to address the source of our concerns. We seek Tribal Consultation with CMS leadership on this matter.

**Background**

This issue first arose when CMS changed its provider-based rules, effective April 7, 2000. Suddenly, many IHS and tribal clinics were no longer provider based because they were not administratively integrated with a hospital, were not within sufficient proximity to a hospital, or failed to meet other new requirements. In order to address this problem, CMS created a work-around to prevent Indian health system clinics from being devastated by the reduction in reimbursement rates that would result from losing their provider based status. This work-around involved "grandfathering" provider-based Tribal clinics and later, when CMS interpretations of hospital conditions of participation created additional problems, allowing some of the grandfathered provider-based clinics to enroll as grandfathered Tribal FQHCs. CMS eventually removed date restrictions for grandfathered provider-based Tribal clinics, but not for grandfathered Tribal FQHCs.

Over the years, CMS has made a number of policy decisions to continue providing the IHS AIR to Indian health system outpatient clinics despite various other changes in CMS policy. However, these work-arounds have left an inconsistent patchwork of payment rates that TTAG believes should, in fulfillment of CMS's treaty and trust responsibilities, be reconciled so that all Indian health system outpatient clinics that elect to do so may receive the IHS AIR. This is of particular importance in fulfilling the purpose of the ISDEAA and preventing Tribes from being penalized for having assumed control over their own clinics. Under CMS's current policy, if a tribe never exercised its ISDEAA rights to enter into a contract or compact to operate a clinic, and it remained under the control of the IHS, there is no question it would be provider based and allowed to bill at the IHS AIR. A tribe's choice to exercise its rights under the ISDEAA to assume control of a clinic previously operated by the IHS should not come with a federal penalty in the form of lower Medicare reimbursement. Such a policy thwarts the will of Congress by creating an artificial barrier to Indian self-determination.

**TTAG's Proposed Regulatory Changes**

In its June 10, 2021 letter, which we attach and submit as part of this response to comments, the TTAG asked CMS to make the following changes to its regulations:

***Amend 42 C.F.R. 405 by adding the following section XXX (new):***

Notwithstanding any other provision of law, federally-qualified health centers and other outpatient facilities operated by the IHS or by an Indian Tribe or Tribal Organization under the Indian Self Determination Act (Pub. L. 93-638) may elect to be reimbursed for their covered

services at the Medicare outpatient per visit rate as set annually by the IHS. Such facilities shall also be paid separately for covered services furnished outside the scope of the facility benefit under the applicable methodology or fee schedule.

*Amend 42 CFR 405.2462(d) as follows (new language is underlined; deleted language is in brackets and all-caps):*

42 C.F.R. 405.2462 (d) Payment to [GRANDFATHERED] tribal FQHCs. (1) A “[GRANDFATHERED] tribal FQHC” is a FQHC that:

(i) is operated by a tribe or tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA);

(ii) [WAS BILLING AS IF IT WERE PROVIDER-BASED TO AN IHS HOSPITAL ON OR BEFORE APRIL 7, 2000; ] and

[ (iii) ] Is not operated as a provider-based department of an IHS or tribal hospital.

(2) At the option of the tribe or tribal organization, a [A GRANDFATHERED] tribal FQHC is paid at the Medicare outpatient per visit rate as set annually by the IHS.

(3) The IHS payment rate is not adjusted:

(i) By the FQHC Geographic Adjustment Factor:

(ii) For new patients, annual wellness visits, or initial preventive physical examinations; or

(iii) Annually by the Medicare Economic Index or a FQHC PPS market basket.

(4) The IHS payment rate is adjusted annually by the IHS under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Pub.L. 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(5) A tribal FQHC paid under the IHS payment rate is exempt from the cost-reporting requirements of 42 CFR 405.2470.

(6) A tribal FQHC paid under the IHS payment rate may be paid separately for vaccines and other non-FQHC services under the applicable fee schedules or, for services reimbursed on a facility-specific cost basis, on the basis of limited cost reports addressing those services.

(7) A tribal FQHC may annually elect to be paid instead under the applicable FQHC PPS rate including applicable adjustments.

*Amend 42 C.F.R. 413.65(m) as follows (new language is underlined; deleted language is in brackets and all-caps):*

42 C.F.R. 413.65. Requirements for a determination that a facility or an organization has provider-based status. ... (m) Status of Indian Health Service and Tribal facilities and organizations. Facilities and organizations operated by the Indian Health Services and Tribes will



be considered to be departments of hospitals operated by the Indian Health Service or Tribes if they furnish only services that are billed, using the CCN of the main provider and with the consent of the main provider, as if they had been furnished by a department of a hospital operated by the Indian Health Service or a tribe and they are:

- (1) Owned and operated by the Indian Health Service;
- (2) Owned by the Tribe but leased from the Tribe by the IHS under the Indian Self Determination Act (Pub. L. 93-638) in accordance with the applicable regulations and policies of the Indian Health Service in consultation with Tribes; [OR]
- (3) Owned by the Indian Health Service but leased and operated by the Tribe under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with the applicable regulations and policies of the Indian Health Service in consultation with Tribes; or
- (4) Owned and operated by the Tribe under the Indian Self-Determination Act (Pub. L. 93- 638) in accordance with the applicable regulations and policies of the Indian Health Service in consultation with Tribes.

The TTAG hereby reiterates this request in response to this RFI. We appreciate that CMS has issued this RFI to gather information to address the TTAG's request. However, a number of the questions appear to be focused only on FQHCs and FQHC billing. As an initial matter, we note that we do not believe CMS should have had to create the grandfathered FQHC workaround in the first place. As discussed in our letter, prior to CMS's policy change regarding provider based status, there was no need for this workaround and all tribal clinics were able to bill at the IHS AIR. It was only due to CMS policy changes that did not account for the unique status of the Indian health care system that the FQHC workaround was needed to begin with. As a result, the TTAG does not believe that billing as an FQHC is the only or best solution to this problem, which is why we have also suggested changes to the tribal provider based rules at 42 C.F.R. 413.65(m), and an umbrella rule providing that all outpatient Indian health programs qualify for reimbursement at the AIR regardless how they are enrolled in Medicare.

#### Response to CMS Questions

*CMS seeks information on the kinds and numbers of facilities or clinics that could potentially enroll in Medicare as an FQHC or are already an FQHC paid under the FQHC Prospective Payment System (PPS), and if these clinics are freestanding or provider based.*

- A. The TTAG does not have this information. All outpatient tribal clinics are defined by law to be FQHCs, so they could potentially enroll as FQHCs. However, few elect to do so due to the burden of submitting FQHC cost reports. How many providers may or may not be able to enroll as FQHCs is not germane to the request made by the TTAG to CMS that all outpatient clinics be able to be reimbursed at the IHS OMB rate.

As the proposed rule points out, there are only 7 grandfathered tribal FQHCs, demonstrating the limitations of this workaround for the rest of the tribal health system.

The TTAG has requested of CMS leadership that all tribal outpatient clinics who elect to do so be able to bill at the IHS OMB rate without having to meet any requirements otherwise applicable to FQHCs.

*CMS also seeks information on the relative operating costs of IHS- and tribally operated outpatient clinics compared to non-tribal FQHCs.*

- A. The TTAG does not believe this information is pertinent to the issue presented to CMS. The TTAG has not requested that CMS determine a separate payment rate for tribal programs, and the any cost differences between IHS/Tribal and other forms of FQHCs are not relevant to the TTAG's request, which is that all IHS/Tribal facilities be eligible for payment at the same IHS-determined rate. The IHS uses cost-based reporting to generate rates reviewed and approved by OMB specific to the IHS system. The TTAG's proposal is simply that all outpatient facilities – IHS and tribal – be able to bill at that rate, regardless of how Medicare reimburses FQHCs. The TTAG did not request a comparison between the two rates, as the request was for all IHS and tribal clinics who elect to do so be able to bill at the same IHS AIR rate as other IHS Tribal clinics.

*CMS seeks comment on how the IHS AIR, based upon a limited number of hospital cost reports, relates to costs in such clinics and the kinds of services that the clinics furnish.*

- A. The TTAG does not believe that an inquiry into the AIR would help us resolve the issue. The IHS AIR has long been recognized as a proper reimbursement rate for IHS and Tribal facilities. The agency started this inquiry because of our request to extend the AIR to all IHS and Tribal facilities. As noted above, IHS uses cost-based reporting to generate rates, which OMB approves. The AIR is already fully vetted before being finalized. We do not believe that further inquiry will yield valuable results.

*CMS seeks comment on the concerns that the AI/AN community may have on issues regarding access or inequity care in situations where a payment differential exists.*

- A. The TTAG believes that there is an equity issue when a facility's Medicare designation determines the rate they can be reimbursed, when that designation is tied to whether IHS or a tribe operates the facility. The Indian health system is heavily reliant on third-party reimbursement to fund our operations, and inequities in reimbursement create inequities in funding. These inequities impact our ability to fund health care for our patients.

*CMS seeks comment on the impact of payment increases on Medicare and program integrity.*

- A. The TTAG's proposal would result in increased payments by Medicare to the Indian health system, but any concerns over program integrity are misplaced. Medicare payments to Indian health care facilities are a rounding error compared to Medicare payments as a whole. Allowing all Indian health clinics to bill at the IHS AIR would have zero impact on program integrity. Moreover, such concerns are wholly misplaced concerning payments for Indian health. The United States has a treaty and trust

responsibility to provide health care to American Indians and Alaska Natives, and the Congress specifically authorized Indian health care providers to bill the Medicare program in order to bring critical federal resources to the Indian health system. There were no program integrity issues then, and there are none now.

*CMS seeks comment on whether CMS could address this issue by making payment adjustments to the FQHC PPS under 1834(o)(1)(A).*

- A. The TTAG believes that CMS should exercise its authority to authorize all IHS clinics to bill at the same IHS AIR as a matter of health equity. There is no reason for CMS Medicare FQHC staff to reinvent the wheel by creating some new rate for tribal clinics. A rate already exists for tribal clinics – the IHS AIR which is already available to some tribal clinics. It should be made available to all of them.

### **Conclusion**

The TTAG thanks the agency for the telehealth flexibilities 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 the agency should allow for audio-only telehealth to 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.

In this letter, we have also addressed reimbursement. First, we would like to see parity in reimbursement for COVID-19 vaccinations. We believe that reimbursements must be sufficient to allow providers to provide vaccinations without diverting funds from other areas of care. Finally, we look forward to furthering conversations on our request to reimburse all IHS and Tribal providers at the All-Inclusive Rate. Thank you in advance for your consideration of our comments.

Sincerely,



W. Ron Allen, CMS/TTAG Co-Chair  
Chair/CEO, Jamestown S’Klallam Tribe