

# Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

## TTAG PRIORITY LIST<sup>1</sup>

### MEDICARE ISSUES

#### Increase Reimbursement to Tribal Hospitals for COVID-19 Testing

Novitas, the CMS MAC for IHS and tribal providers, is currently only allowing IHS and Tribal hospitals performing COVID-19 laboratory tests to be reimbursed a nominal dispensing fee, even though they are often the entities who are analyzing the test themselves. This is in error, and CMS should instead clarify that they should be 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.

#### Update Chapter 19 of the Medicare Claims Processing Manual with the TTAG

For some time now, CMS has been working on revisions to Chapter 19 of the Medicare Claims Processing Manual, but has not included the TTAG in that process. Chapter 19 of the Medicare Claims processing manual is out of date and full of internal inconsistencies. This has resulted in billing disputes with Novitas, the CMS IHS/tribal MAC. CMS should schedule a workgroup to work through TTAG suggested revisions to the claims processing manual.

#### IHS/Tribal Accommodation under Hospital Acquired Condition Rules

Under CMS's rules for assessing hospitals' performance in avoiding hospital acquired conditions, low volume hospitals are often listed among the lowest performing hospitals (in the lowest quartile of all hospitals nationally), even though they may have few hospital-acquired conditions. This is due to the formula CMS has elected to use, which uses a flawed methodology. Under the current formula, many of the best performing IHS and tribal hospitals are being reported as in the lowest quartile for hospital acquired conditions, when that is not the case. The TTAG requests that CMS change its regulation, or issue guidance that would account for the formula error that is inaccurately reporting many IHS and tribal hospitals as low performing.

#### Increase Flexibility in Medicare Definition of Telemedicine Services

COVID-19 has demonstrated the importance of telehealth to increase access to providers during the pandemic. But it has also demonstrated it can 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. In addition, much of Indian country is located in rural areas and lacks access to more advanced methods of audio and video real-time communication. As a

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<sup>1</sup> This priority list was approved by the Tribal Technical Advisory Group on November 19, 2020.

result, Medicare should allow telehealth to be provided through audio-only telephonic and two-way radio communication methods when necessary.

#### 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 even if they do not enroll in a provider agreement. Section 206 of the IHCA 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.

#### 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 would like these practices to stop.

#### Allow Direct Sponsorship of Part B Premiums by Indian health programs.

Medicare reimbursements are a vital source of revenue for Indian health programs, helping to subsidize chronically insufficient direct IHS funding, fulfill the federal trust responsibility for Indian health, and reduce health disparities experienced by AI/AN patients. However, many AI/AN individuals cannot afford to pay the monthly Part B premiums, and even those who can have little incentive to do so, given their right to receive care at no charge from the Indian health system. For these reasons, some Indian health programs "sponsor" the premiums for their beneficiaries – paying the premium on their behalf. Many State Medicaid programs do the same, and for similar reasons. But unlike States, which can simply pay the premiums for all the individuals they sponsor in one lump sum payment, currently Indian health programs are only allowed to reimburse Part B premiums, after their individual beneficiaries have paid the premium up front. This is a huge disincentive to Part B enrollment, and a significant administrative burden on tribes that wish to sponsor enrollment. TTAG supports eliminating Part B premiums entirely for AI/AN beneficiaries. However, if premiums are retained, Indian health programs should be given the same option as States, to pay them directly on behalf of their beneficiaries.

#### Make the IHS Outpatient Encounter Rate Available to All Indian Outpatient Programs that Request It (Permanent fix to Grandfathered Tribal Provider/FQHC Issue)

For nearly 20 years, the TTAG has been urging Medicare to authorize all Indian outpatient programs that request it to bill at the IHS outpatient encounter rate. Currently, otherwise similar clinics are paid at dramatically different rates depending upon whether they qualify as a “provider based facility,” a “grandfathered Tribal FQHC,” a non-grandfathered Tribal FQHC, or none of the above—categories that largely depend on whether and when the facility was last operated by the IHS. Consequently, otherwise similar Indian outpatient clinics are now paid at dramatically different rates, and modern new clinics may be paid at lower rates than older ones that are less costly to operate. CMS’s tribal provider based rules at 42 C.F.R. § 413.65(m) and 42 C.F.R. § 405.2462 need to be updated to allow all Indian outpatient programs that request it to be able to bill at the IHS Outpatient encounter rate.

#### Provide Relief from Medicare Part B Penalties for AI/AN elders.

Medicare Part B imposes penalties for individuals who delay enrollment once they are eligible. Penalties do not apply to individuals who have coverage through their own employment or their spouse’s. Currently, however, there is no such exception for individuals who are eligible for care from the Indian Health Service - even though they, like beneficiaries of employment-based insurance plans, do not need additional coverage and should not be required to pay for it. While the TTAG believes that AI/AN individuals should be exempt from all Medicare Part B premiums, if Part B premiums are retained, at a minimum IHS coverage should be deemed creditable coverage so that AI/AN Part B enrollees are not subject to late-enrollment penalties.

#### Community Education to Prevent Predatory Medicare Advantage Enrollment Practices that some plans practice

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. Indian Health Providers are not contracted providers under Medicare Advantage plans, and so the plans do not pay IHS/Tribal (I/T) facilities. In addition, Indian Health Providers are unable refer patients to 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 plans. This service is lacking.

#### 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 population served. 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 serving AI/ANs. 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.

#### Ensure IHCPs that Continue to Use RPMS Can Obtain Hardship Exemptions

On September 16, 2020, IHS issued a Dear Tribal Leader letter warning Tribal providers participating in the Medicare Promoting Interoperability Program that continue to use RPMS may see negative payment adjustments if they have submitted more than five hardship exceptions (maximum number allowed). We are concerned that many IHS and tribal providers that continue to use RPMS may have reached the maximum number of hardship allowances. We request assistance from CMS in ensuring that IHCPs are not subject to penalties while the IHS considers whether to update RPMS or not while moving to a different system.

#### Exempt ITU DME Suppliers from Competitive Bidding Process

Indian health care provider 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 so as to allow Indian health care providers to access and bill for DME.

### **MEDICAID ISSUES**

#### Extend Grace Period for Four Walls Limitation Due to COVID-19

CMS will begin enforcing a four walls limitation for IHS and tribal providers of clinic services beginning in January 2021. This limitation will prevent IHS and tribal providers who are enrolled in Medicaid as providers of clinic services from billing the Medicaid program for services provided outside the physical four walls of the facility, including vital services they have furnished for decades at the off-site locations where they are most effective, such as schools, community centers, patients' homes, and by mobile crisis response teams. For over a year, the TTAG has made multiple requests for CMS to extend the grace period, starting even

before COVID-19 struck. An extension is even more urgent now: the COVID-19 emergency response necessarily diverted State Medicaid agencies and tribal providers from working together to mitigate the problem by amending their State Medicaid plans. During the grace period, we also urge CMS to reconsider the four-walls limitation. It is based on what we believe is a misreading of the Social Security Act and CMS's regulations, and it is profoundly contrary to the public health, especially in the age of COVID-19.

#### Encourage States to Increase Medicaid Telehealth Reimbursement for IHCPs

States have broad authority to authorize reimbursement for telehealth services and many States authorize reimbursement for telehealth services at the same rates they reimburse in-person services. CMS should issue guidance to States confirming that they can authorize Medicaid reimbursement for telehealth services at the IHS OMB rates.

#### Issue Medicaid SHO Letter to Managed Care Organizations

Indian health care providers continue to have difficulty being paid correctly by Medicaid Managed Care organizations. States often do not do enough to enforce the Indian provisions of the Medicaid managed care rule at 42 C.F.R. § 438.14, and CMS has not done enough to enforce State compliance with these requirements. This issue is perennial and consistent and cannot continue to be addressed on a case by case basis. Many of these issues have persisted for years. CMS should issue a State Health Official letter informing States that they will be required as a condition of approving any managed care State Plan Amendment or waiver to include compliance with the requirements at 42 C.F.R. § 438.14 as a condition of payment in their contracts with managed care organizations. In addition, CMS should also require that MCOs deem all Indian health care providers to be in-network regardless of whether they enter into a network provider agreement or not.

#### Shield IHCPs from State Benefit Cuts or Enrollment Limitations

The COVID-19 pandemic may create significant financial pressures on State Medicaid programs whose budgets are tied to State tax revenues. The TTAG is concerned that in the coming year, many States may be forced to impose cuts to optional benefits or limit enrollment like they did in response to the great recession in 2008-2009. During that period, CMS approved several State waivers that exempted Indian health care providers from those cuts in services and enrollment freezes. If the need arises, CMS must be willing to entertain similar waivers that exempt cuts for services received through IHS and tribal providers that are eligible for 100 percent FMAP reimbursement.

### **OTHER ISSUES**

#### Approve TTAG Request for Indian Safe Harbor to Anti-Kickback Statute

Since 2012, the TTAG has requested that the HHS Office of Inspector General (OIG) approve its request for an Indian-specific safe harbor to the Anti-Kickback Statute. Federally

qualified health centers have their own safe harbor to the Anti-Kickback Statute. While tribal outpatient clinics are defined by law to be federally qualified health centers, this safe harbor is not broad enough to include all IHS and tribal health care providers, including hospitals. As a result, the TTAG developed an Indian-specific safe harbor to the Anti-Kickback statute that is based on the safe harbor for FQHCs. To date, OIG has not acted on this request.