

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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TTAG Medicare and Medicaid Legislative Priorities¹

- **Authorize Medicaid reimbursements for Qualified Indian Provider Services and Urban Indian Organizations.**

Background: IHS and tribal facilities are experiencing significant economic disruption as a result of the COVID-19 pandemic. This has intensified the need to maximize 3rd party reimbursements for the Indian health system. Currently, Indian health care providers only receive reimbursement for health services that are authorized for all providers in a state. Thus, we request that Congress authorize Indian health care providers across all states to receive Medicaid reimbursement for all mandatory and optional services described as “medical assistance” under Medicaid and specified services authorized under the Indian Health Care Improvement Act (IHCIA)—referred to as Qualified Indian Provider Services—when delivered to Medicaid-eligible American Indians and Alaska Natives.

Legislative Text:

For Qualified Indian Provider Services:

Amend subsection 1905(a)(2) by striking the “and” before subparagraph (C) and inserting the following:

“and (D) Qualified Indian Provider Services (as defined in subsection (l)(4) of this section) and any other ambulatory services offered by an Indian Health Care Provider and which are otherwise included in the plan.”

Add a new subsection 1905(l)(4) as follows:

“(A)(i) The term “Qualified Indian Provider Services” means all services described in paragraphs (1) through (29) of section 1905(a) and all services of the type described in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) sections 1616, 1616l, 1621b, 1621c, 1621d, 1621h, 1621q, 1665a, 1665m1, when furnished to an individual as a patient of an Indian Health Care Provider (as defined in (B) of this subsection) who is eligible to receive services under the State plan and is eligible to receive services from the Indian Health Service.”²

“(ii) Notwithstanding any other provision of law, Qualified Indian Provider Services may be provided by authorized non-physician practitioners working within the scope of their license, certification, or authorized practice under federal, state, or tribal law.”

¹ This priority list was approved by TTAG on November 18, 2020

² These citations include the Community Health Aide Program (1616l), health promotion and disease prevention (1621b), diabetes prevention, treatment, and control (1621c), home- and community-based services (1621d), and behavioral health services (1665a).

CODIFY IN FEDERAL LAW THE DEFINITION OF IHCP FROM FEDERAL REGULATIONS AT 42 CFR 447.51 --

Amend Social Security Act Section 1905 (l)(4) by inserting the following as a new subparagraph (B): “(B) The term “Indian Health Care Provider” means a health program operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act [25 U.S.C. 1603]) or inter-tribal consortium (as defined in section 5381 of title 25) or through an Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act) operating pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act or as a permanent program within the IHS direct care program.”

For 100 Percent FMAP for Services Provided by Urban Indian Organizations:

SEC. 1. EXTENSION OF FULL FEDERAL MEDICAL ASSISTANCE PERCENTAGE TO URBAN INDIAN ORGANIZATIONS.

Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking “Indian Health Care Improvement Act)” and inserting “Indian Health Care Improvement Act) or through an Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act) pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act or as a permanent program within the IHS direct care program.”

- **Provide reimbursements for services furnished by Indian Health Care Providers outside of an IHS or Tribal Facility.**

Background: The COVID-19 pandemic has created a safety need for providers to see AI/AN patients in non-traditional settings outside of the traditional “four walls” of a clinic or hospital. Many IHS and Tribal sites are setting up mobile units and outdoor triage centers and provide more outpatient care. Without the ability to bill for these services, it will create a significant financial strain on the Indian health system. Ensuring reimbursements for IHS and Tribal providers follow wherever the service is delivered will improve the timeliness and accessibility of care during the COVID-19 emergency and help bolster desperately needed financial resources.

Legislative Text:

Amend section 1905(a)(9) [42 U.S.C. 1396d(a)(9)]³ by inserting after “address”:

“and including such services furnished in any location by or through an Indian Health Care Provider as defined in (l)(4)(B)”

- **Ensure parity in Medicare reimbursement for Indian Health Care Providers.**

³ The citation is to the definition of “Federally-qualified health center”.

Background: IHS and Tribal facilities are experiencing significant economic disruption and loss of third party revenues, including Medicare billing, as a result of the COVID-19 pandemic. This crisis is exacerbated by the fact that Indian health care providers are not fully reimbursed for the cost of providing Medicare covered services. Unlike other Medicare providers, Indian health care providers do not bill the AI/AN Medicare patients they serve. This means that as a general rule, Indian health care providers only receive 80 percent of reasonable charges, and are not paid the remaining 20 percent by their patients. As a result, IHS and Tribal facilities are only being paid 80 cents on the dollar by the Medicare program compared to other providers. This legislation is needed to ensure that the United States reimburses Indian health care providers in full for Medicare services they provide to AI/AN people, and to ensure that AI/AN People can seek services outside the Indian health system without having to face significant cost sharing burdens they may not be able to afford. The United States has a federal trust responsibility to provide health care for AI/ANs, and cost-sharing requirements are inconsistent with this obligation. Medicaid exempts AI/ANs from cost-sharing, and Medicare should do the same.

Legislative Text:

(a) IN GENERAL.—Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended— by inserting before the period at the end the following:

“, and (g) notwithstanding any provision of law,

(1) IN GENERAL.—No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this title.

(2)) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—Payment due under this title to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under such title, shall be at 100 percent of the applicable rate and may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this title who is an Indian.”

- **Include pharmacists, licensed marriage and family therapists (LMFTs), licensed professional counselors, and other providers as eligible provider types under Medicare for reimbursement to IHS, Tribal health programs, and Urban Indian Organizations.**

Background: There is a severe, longstanding, and well-documented shortage of healthcare professionals in Indian Country and throughout the Indian healthcare system. Particularly in more remote and rural locations, IHS and Tribal health care programs struggle to attract and retain qualified providers. Because of this shortage, Indian Healthcare programs rely extensively and increasingly on the services of other types of licensed and certified non-physician practitioners, including Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), Certified Community Health Aides and Practitioners (CHAPs), Behavioral Health Aides and Practitioners (BHAPs), and Pharmacists.

These practitioners receive rigorous training that equips them to furnish many of the same services that physicians and other Medicare-recognized professionals do, and like them, they are subject to strict licensing, certification, ethical, and continuing education requirements. CHAPs are trained to provide primary and emergency health care services, and they are the only healthcare providers in dozens of remote Alaska Native communities. LMFTs, LPCs, and higher-level BHAPs are qualified to furnish many of the same services that psychiatrists, CSWs, and psychologists do. For example, pharmacists are professionally trained to furnish a wide array of related healthcare services and they serve a vital role in many Indian health programs. Among other services, pharmacists in Indian programs deliver clinic-based, protocol-driven care on behalf of physicians, including anticoagulation, tobacco cessation, cardiovascular risk reduction, asthma/COPD stabilization, and medication-assisted treatment (MAT) for substance use disorders.

All these providers furnish essential, effective, and high-quality care that is covered by many Medicaid programs, yet Medicare does not cover them, nor do the many non-governmental healthcare plans and health insurers that follow Medicare's lead. This deprives Indian Health programs of critically needed federal reimbursement for vital healthcare services to AI/ANs, needlessly straining the programs' already overtaxed resources and jeopardizing their ability to serve their patients. This is a longstanding problem that has become even more urgent as Indian Country struggles to bring adequate resources to the fight against COVID-19.

Legislative Text:

--Amend subsection 1861(s) of the Social Security Act [42 U.S.C. 1395x(s)] (Definition of "Medical and Other Health Services") by adding a new subparagraph (II) as follows:

(II) Indian health program pharmacist and non-physician practitioner services as defined in subsection (kkk).

--Amend subsection 1861 [42 U.S.C. 1395x] (Definitions) by adding a new subsection as follows:

(kkk) "Indian health program pharmacist and non-physician practitioner services" means services furnished by or through the Indian Health Service, any Tribal Health Program (as defined in section 4 of the Indian Health Care Improvement Act [25 U.S.C. section 1603]), or any Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act) that would otherwise be covered if furnished by a physician or as an incident to a physician's service and that are furnished within the scope of licensure or certification by a licensed marriage and family therapist, licensed professional counselor, community health aide or practitioner certified by the Community Health Aide Program Certification Board, behavioral health aide or practitioner certified by the Community Health Aide Program Certification Board, licensed pharmacist, and such other licensed or certified professionals as the Secretary may authorize.

- **Expand telehealth capacity and access in Indian Country by permanently extending waivers under Medicare for the use of telehealth and enacting certain sections of the CONNECT to Health Act.**

Background: During the COVID-19 crisis, telehealth and telemedicine are critical to providing health care services to AI/AN people. Unfortunately, rural tribal nations may be unable to provide these services due to the lack of broadband capacity or infrastructure in their area. COVID-19 has dramatically increased the need to connect Medicare patients to their providers through telehealth. This increased need is likely to continue after the national emergency has passed, particularly for patients in the Indian health system. In addition, as more AI/AN patients become accustomed over time to the telehealth model, it is likely to play a more significant role as a mechanism for delivering healthcare well beyond the end of this pandemic.

To this end, the *Coronavirus Preparedness and Response Supplemental Appropriations Act* provided the Secretary of HHS with the ability to waive telehealth restrictions during national emergencies. In doing so, it enacted Section 9 of the bipartisan Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019 (H.R. 4932, S. 2741). The CONNECT for Health Act was most recently introduced in October 2019 and has the support of the American Medical Association and over 100 other organizations.

Section 3 of the CONNECT to Health Act would provide HHS with the ability to waive certain telehealth restrictions outside of the national emergency context. These waivable restrictions include limitations on provider types, technology, geographic area, and services. Section 8 of the CONNECT to Health Act would eliminate originating site requirements with respect to facilities operated by IHS, a Tribe or Tribal organization, or a Native Hawaiian health care system. Originating site requirements currently mandate that a patient be in a particular location such as a physician's office, hospital, or other specified clinical setting. These requirements prevent patients from being able to receive telehealth services in their homes, community centers, or other non-clinical locations. In addition, Sections 4, 5, 7, and 14 of the CONNECT for Health Act affect use of telehealth for mental health services, emergency care, rural health clinics, and Federally Qualified Health Centers (FQHCs); and also expand the list of health professionals who may provide services through telehealth – all of which have immediate and long-term benefits to the Indian health system. With the urgent need to maximize telehealth flexibility in response to COVID-19, tribal nations strongly recommend that Congress not only permanently extend the existing waiver authority for the use of telehealth under Medicare, but to also enact certain sections of the CONNECT for Health Act.

Legislative Text:

See Sections 3-5, Sections 7-8, and Section 14 of H.R. 4932 or S. 2741

- **Eliminate Medicare Part B Premiums for IHS eligible people.**

Background: Medicare and Medicaid reimbursements are vital sources of funding for Indian health programs. Together they supplement the dramatically inadequate direct funding from IHS, and helping fulfill the federal trust responsibility for Indian health. But while federal law

exempts IHS beneficiaries from paying *Medicaid* premiums and other Medicaid cost sharing, there is no such exemption for *Medicare*. Consequently, Indian health programs can receive Part B reimbursement only if their eligible patients enroll in the program, and only if those patients either pay the monthly premium themselves or have it paid on their behalf by a sponsoring tribe, Indian health programs, or State Medicaid program. The “standard” Part B premium has been rising steadily over the years: for 2020 it stands at \$144.60 per month for individuals earning less than \$87,000 per year, with much higher premiums for those earning more. Most AI/AN elders cannot afford the standard premium, and even those who could have little incentive to pay it, given their right under the trust responsibility to receive no-charge care from the Indian health system. The Medicare Part B Premium thus presents a major obstacle to Medicare reimbursement for Indian health programs, a significant and growing cost for sponsoring tribes and Medicaid programs, and a breach of the federal trust responsibility for Indian health. Congress had it right when it waived Medicaid cost sharing for IHS beneficiaries, and there is no logical reason to treat Medicare premiums differently. Congress should exempt IHS beneficiaries from Medicare Part B premiums.

Legislative Text:

To be drafted.