



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

March 17, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS Tribal Technical Advisory Group Priorities

Dear Administrator Brooks-LaSure:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to provide you the TTAG policy priorities. The full TTAG membership formally adopted these priorities during its March 15-16, 2023 meeting.

As you know, the TTAG serves as an advisory body to CMS, providing expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for American Indians and Alaska Natives (AI/ANs) served by Medicare, Medicaid, CHIP, or any other health care program funded by CMS. The attached TTAG regulatory/administrative and legislative priorities can provide a roadmap for CMS to address health equity in the Indian health system.

The TTAG regulatory/administrative priorities propose specific steps CMS can take, on its own authority, to expand the Medicaid services available to AI/ANs, empower Tribal programs to design and tailor Medicare and Medicaid services to their unique needs and cultures, as well as to provide more uniform and equitable Medicare and Medicaid reimbursement to Tribal programs. For example, the current priorities call on CMS to:

- Expand Medicaid and Medicare coverage of telehealth services, including audio-only services, to the greatest extent possible, and reimburse these services at the same rate as in-person services.
- Revise its interpretation of the Medicaid “clinic” benefit to eliminate the “four walls” restriction and to cover services furnished by clinic staff in schools, community centers, patients’ homes, and any other appropriate location.

The TTAG legislative priorities propose changes that are beyond CMS’s current authority and would require changes to federal statutes. While CMS generally cannot advocate directly for legislative changes, it can support this effort by providing Congress with thorough and timely technical assistance on any proposed legislation related to the TTAG priorities. These priorities include:

CMS TTAG Letter to CMS Administrator Brooks-LaSure

Re: CMS Tribal Technical Advisory Group Priorities

March 17, 2023

Page 2 of 2

- Authorize 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—referred to as Qualified Indian Provider Services—when delivered to Medicaid-eligible AI/AN beneficiaries by Indian health care providers.
- Eliminate Medicare cost-sharing and premiums for AI/AN beneficiaries, as is already the case for Medicaid-covered services.

The TTAG leadership looks forward to the continued partnership with CMS in developing policies and programs that work for and with the Indian health system in accordance with the nation’s trust responsibility to provide for the health of Tribal nations. We appreciate your consideration of the TTAG priorities and look forward to engaging with the agency further.

Sincerely,



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

Attachment(s):

- CMS Tribal Technical Advisory Group Priorities Summary
- CMS TTAG Medicaid Policy (Regulatory/Administrative) Priority Issues
- CMS TTAG Medicare Policy (Regulatory/Administrative) Priority Issues
- CMS TTAG Medicaid (Legislative Fixes) Priorities
- CMS TTAG Medicare (Legislative Fixes) Priorities

**CMS TRIBAL TECHNICAL ADVISORY GROUP PRIORITIES
SUMMARY
MARCH 15, 2023**

Medicaid Administrative Priorities

1. CMS should publish guidance informing states that they can permanently reimburse telehealth services performed by Indian health care providers at IHS encounter rates.
2. CMS should fix the four walls issue and authorize providers of clinic services to be reimbursed for services provided outside the four walls of the clinic.
3. CMS should grant state Section 1115 waiver requests to protect AI/AN beneficiaries from state Medicaid budget reductions.

Medicaid Legislative Priorities

1. Congress should authorize all Indian Health Care Providers to bill Medicaid for all Medicaid optional services as well as specified services authorized under the Indian Health Care Improvement Act regardless of whether the State authorizes those services for other providers.
2. Congress should fix the four walls issue by permanently amending the definition of “clinic services” to authorize reimbursements for services furnished by Indian Health Care Providers outside of an IHS or tribal facility.
3. Congress should permanently authorize a 100 percent Federal Medical Assistance Percentage for services received through Urban Indian Organizations.

Medicare Administrative Priorities

1. CMS should ensure that the IHS Outpatient Encounter Rate is available to all Indian outpatient programs that request it.
2. CMS should require Part D plans to promptly pay Indian Health Care Providers without unlawfully imposing discounts as a result of an Indian Health Care Provider exercising its right to discounted pharmaceuticals under Section 340B or the federal supply schedule.
3. (A) CMS should require Medicare Advantage plans to deem Indian Health Care Providers in-network regardless of whether they enroll as a participating provider. CMS should require Medicare Advantage to reimburse Indian Health Care Providers at IHS OMB rates. CMS should develop and implement an Indian Addendum for Medicare Advantage plans.
3. (B) CMS should develop frequently asked questions to ensure that brokers are not using predatory practices to drive enrollment.
4. CMS should permanently cover all telehealth services it permitted during the public health emergency, expand the types of services it permits to be conducted via telehealth, and expand the definition of permitted telehealth to include audio-only telephonic and two-way communication methods, particularly in rural areas.
5. CMS should exempt Indian health care durable medical equipment Medicare suppliers from the competitive bidding process.

Medicare Legislative Priorities

1. (A) Congress should exempt AI/AN beneficiaries from Medicare premiums and deductibles, just as Congress has waived Medicaid cost sharing for IHS beneficiaries.
1. (B) HHS calculates a Medicare cost-based rate for Indian Health Care Providers, but Medicare then only reimburses them for 80% of those costs. Congress should require Medicare to reimburse Indian Health Care Providers for 100% of the calculated cost of their services.

2. Congress should make pharmacists, certified community health aides and practitioners, behavioral health aides and practitioners, and dental health aide therapists eligible for Medicare reimbursement for Indian health care providers.
3. Congress should eliminate originating site requirements, authorize the Secretary of HHS to permanently authorize telehealth services in Indian Country, and enact certain other telehealth flexibilities embodied in the CONNECT for Health Act (H.R. 2903/S. 1512).
4. Congress should exempt IHS hospitals from the Hospital Star Rating System, as it does for Veterans Health Administration and Department of Defense hospitals.
5. Congress should change the Hospital Acquired Condition formula so that it no longer harms low-volume IHS/Tribal hospitals.

Other Priorities

The HHS Office of Inspector General (OIG) should create an Indian safe harbor to the Anti-Kickback statute to ensure that all Indian Health Care Providers have the same flexibility as federally qualified health centers.

CMS TTAG MEDICAID POLICY (REGULATORY/ADMINISTRATIVE) PRIORITY ISSUES
March 15, 2023

Medicaid Priority #1: Encourage States to Authorize Medicaid Telehealth Reimbursement for Indian Health Care Providers at the OMB Encounter Rate

States have broad authority to authorize reimbursement for telehealth services and many States reimburse for telehealth services at the same rates as in-person services. CMS should issue specific written guidance to States (e.g., a State Health Officials Letter or CMS Informational Bulletin) confirming that they can reimburse telehealth services at the IHS OMB encounter rates, not only during the PHE but also permanently.

Medicaid Priority #2: Approve TTAG Request for Indian Safe Harbor to Anti-Kickback Statute

Since 2012, the TTAG has requested that the HHS 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. The TTAG has repeatedly requested OIG adopt this safe harbor, but the OIG has declined to do so. Most recently, the OIG declined this request in its Fall 2021 Semi-Annual Report, stating without explanation that it believed existing safe harbors were sufficient, but indicating it might consider the topic again in a future rulemaking. OIG did not respond directly to TTAG or notify it that the issue was addressed in the OIG report. TTAG disagrees that existing safe harbors are sufficient, and requests the OIG meet with us and explore the issue in more detail. This is a health equity issue. Many Indian health care providers do not have access to the FQHC safe harbor, and therefore lack the same flexibility the FQHC safe harbor provides to allow them to more easily access care from outside primary and specialty care providers. There is no reasoned basis for OIG to allow some Indian health care providers access to an FQHC type safe harbor but not others.

Medicaid Priority #3: Revisit Four Walls Interpretation

CMS has interpreted the Medicaid clinic benefit to exclude services furnished offsite by clinic staff, except to homeless individuals. IHS and tribal programs that are enrolled in Medicaid as providers of clinic services have long provided, and been reimbursed by the Medicaid program for, services provided by their staff 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. CMS clearly recognizes the adverse impacts of this cramped interpretation of the statute and has worked to mitigate them, by granting and extending an enforcement grace-period, and allowing tribal clinics to be redesignated as "FQHCs," which have no four-walls restriction. However, the four walls option has not been implemented by all states with tribal programs, and even in States that have taken it up, the option leaves out some services and is completely unavailable to programs operated directly by the Indian Health Service. While the TTAG appreciates these efforts by CMS, we believe the approach is misguided, and that CMS has the authority to interpret the clinic benefit more broadly, to include offsite services furnished to all clinic patients. CMS's current interpretation of the benefit, in our view, is based on a misreading of the Social Security Act and CMS's regulations, and it is profoundly contrary to the public health, especially in the wake of the COVID-19 pandemic. We request that CMS revisit and revise its interpretation.

Medicaid Priority #4: Shield IHCP's from state benefit cuts or enrollment limitations

The TTAG is concerned that some States will soon consider cutting their Medicaid program benefits and enrollment rates, as the nation grapples with an economic downturn and the States face the eventual loss of the enhanced federal Medicaid payment rates they have received during the COVID-19 Public Health Emergency. Even though States receive 100% FMAP for Medicaid services furnished by Indian providers to Indian Health Service beneficiaries, they generally cover tribal programs and AI/AN patients only for the same Medicaid services as other providers and patients. Tribal programs and AI/ANs rely disproportionately on Medicaid services and reimbursements, and they will suffer disproportionately if Medicaid programs are cut with no exception for them. CMS has the authority, under Section 1115, to grant State waiver requests to shield tribal health programs and AI/AN beneficiaries from Medicaid cuts, and has exercised this authority in the past. The TTAG asks CMS to encourage States to apply for such waivers, to create specific guidance and templates States could follow, and to liberally grant State waiver requests, given the vital role Medicaid plays in meeting the federal Trust Responsibility for Indian Health and to reducing long-standing health disparities AI/ANs suffer as a result of colonization, systemic racism, and federal policies that fail to respect tribal sovereignty.

CMS TTAG Medicaid (Legislative Fixes) Priorities
March 15, 2023

Medicaid Priority #1: Authorize Medicaid reimbursements for Qualified Indian Provider Services

In 1976, Congress gave the Indian health system access to the Medicaid program in order to help address dramatic health and resources inequities and to implement its trust and treaty responsibilities to provide health care to American Indians and Alaska Natives (AI/ANs). In order to ensure that States not bear the increased costs associated with allowing Indian health care providers access to Medicaid resources, Congress provided that the United States would pay 100 percent of the costs for services received through Indian health care providers (100 percent FMAP). While Congress provided equal access to the Medicaid program to all Indian health care providers, in practice access has not been equal. Because States have the option of selecting some or none of the optional Medicaid services, the amount and type of services that can be billed to Medicaid varies greatly state by state. So, while the United States's trust and treaty obligations apply equally to all tribes, it is not fulfilling those obligations equally through the Medicaid program. To further the federal government's trust responsibility, and as a step toward achieving greater health equity and improved health status for AI/AN people, we request that Congress authorize Indian health care providers across all states to receive Medicaid reimbursement for a new set of Qualified Indian Provider Services. These would include all mandatory and optional services described as "medical assistance" under Medicaid and specified services authorized under the IHCA when delivered to Medicaid-eligible AI/ANs. This would allow all Indian health care providers to bill Medicaid for the same set of services regardless of the state they are located in. States could continue to claim 100 percent FMAP for those services so there would be no increased costs for the states for services received through IHS and tribal providers. Services received through Urban Indian Organizations would also be made eligible for 100 percent FMAP reimbursement in order to ensure there would be no increased costs to the states for services received through Urban Indian Organizations.

Legislative Language:

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."

"(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."

CODIFY IN FEDERAL LAW THE DEFINITION OF IHCP FROM FEDERAL REGULATIONS AT 42 CFR 447.51 -- Amend Social Security Act Section 1905 (I)(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.”

Medicaid Priority #2: Provide reimbursements for services furnished by Indian Health Care Providers outside of an IHS or Tribal Facility (Four Walls Issue)

The COVID-19 pandemic has increased the need for Indian health providers to see AI/AN patients in non-traditional settings outside of the traditional “four walls” of a clinic or other facility, but such services have always been an essential part of health care service delivery in Indian country. For example, many Alaska Native villages are too small or remote to have a brick-and-mortar clinic of their own, so clinic providers from larger villages in the region periodically travel to the smaller villages to provide services. Even in villages with clinics, access to care is enhanced when services are furnished in non-traditional settings, including schools, community centers, and patients’ homes. Further, at the height of the Covid-19 Public Health Emergency, many IHS and Tribal sites set up mobile units and outdoor triage centers to provide more outpatient care and to limit contagion risks within facilities. It is self-evident that, to maximize access and improve health outcomes, health care services should be furnished, and reimbursable, in whatever setting is most effective and appropriate under the circumstances. Yet, because of a cramped and antiquated interpretation of the Medicaid statute’s definition of “clinic services,” many of the offsite services Indian health providers have long furnished, and those they added in response to COVID-19, will no longer qualify for Medicaid reimbursement once a temporary grace period expires 9 months after the COVID-19 Public Health Emergency ends. Congress should amend the “clinic services” definition to ensure that reimbursements for services furnished by IHS and Tribal clinic services providers will be available wherever the service is delivered.

Legislative Language:

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

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

Medicaid Priority #3: Extension of 100% FMAP for Urban Indian Organizations

The current extension of 100% FMAP for Urban Indian Organizations expires in March 2023. Once it expires, States will once again be able to claim 100% FMAP for Medicaid-covered services furnished by the Indian Health Service, Indian Tribes, and Tribal Organizations, *but not* for those furnished by UIOs. TTAG requests the law be amended to permanently extend 100% FMAP to services furnished by UIOs.

Legislative Language:

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.”

CMS TTAG MEDICARE POLICY (REGULATORY/ADMINISTRATIVE) PRIORITY ISSUES
March 15, 2023

Medicare Priority #1: Make the IHS Outpatient Encounter Rate Available to All Indian Outpatient Programs Who Request It

For many years, the TTAG has been urging Medicare to allow all Indian outpatient programs the option to bill at the same IHS-established and OMB-approved encounter rates that would apply if the programs were directly operated by the IHS. Under current Medicare regulations and policies, programs operated by Tribes and Tribal Organizations under the Indian Self-Determination and Education Assistance Act may lose access to that rate, depending almost entirely on whether and when the program was last operated by the IHS or affiliated with an IHS operated hospital. Regardless of how similar or different they may otherwise be, Indian outpatient programs are now paid by Medicare at dramatically different rates, depending on whether they are operated by a Tribe or the IHS or qualify as a “provider-based facility,” a “grandfathered Tribal FQHC,” a non-grandfathered Tribal FQHC, or none of the above. In effect, Indian Tribes and Tribal Organizations are now financially penalized by the Medicare program for exercising their Indian Self-Determination Act rights, and their ability to provide a wide range of high-quality services to their AI/AN patients is compromised. CMS should adopt a new Medicare regulation, or amend its tribal provider-based and grandfathered tribal FQHC rules at 42 C.F.R. § 413.65(m) and 42 C.F.R. § 405.2462, to allow all Indian outpatient programs that request it to be paid for all Medicare-covered services at the IHS Outpatient encounter rate, and without irrelevant or additional cost-reporting requirements.

Medicare Priority #2: 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 is developing a new Part D Addendum that would address these issues and request CMS to adopt same.

Medicare Priority #3: Part A - 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 for reimbursement purposes, even if they do not enroll in a provider agreement. Section 206 of the IHCA (42 U.S.C. 1621e) 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.

TTAG request CMS to develop and implement a Part C Indian Addendum.

Medicare Priority #3: Part B - Part C Plans - Community Education to Prevent Predatory Medicare Advantage Enrollment Practices

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. Most Indian Health Providers are not contracted providers under Medicare Advantage plans, and so the plans do not pay the IHS/Tribal facilities. In addition, Indian Health Care Providers not contracted to MA plans are unable to refer patients to the plan's 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 plan. TTAG request CMS to develop FAQ's that clarify these issues and require usage by all Part C plans and brokers.

Medicare Priority #4: Increase Flexibility in Medicare Definition of Telemedicine Services

COVID-19 made it necessary for the Medicare program to cover more telehealth services to allow access to providers during the pandemic. But it has also demonstrated the general safety and effectiveness of telemedicine, and the extent to which, even in normal times, it can dramatically 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, and more services should be allowed to be furnished via telehealth. In addition, much of Indian country is in rural areas and lacks access to more advanced methods of audio and video real-time communication, and many AI/AN beneficiaries lack access to smart phones and other audio-video capable devices. As a result, Medicare should allow telehealth to be provided through audio-only telephonic and two-way radio communication methods, not only on a case-by-case basis, but more broadly in service areas where access limitations justify its use. This should be allowed for the widest possible array of services, and not only for mental health services.

The Medicare telehealth flexibilities were extended through FY2024 in the FY2023 Omnibus bill. However, TTAG is requesting CMS provide maximum flexibility in the implementation of these Medicare telehealth flexibilities and make them permanent.

Medicare Priority #5: Exempt ITU DME Suppliers from Competitive Bidding Process

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

CMS TTAG Medicare (Legislative Fixes) Priorities
March 15, 2023

Medicare Priority #1: Part A – Eliminate Medicare Part B Premiums and Deductibles for IHS eligible people

Medicare and Medicaid reimbursements are vital sources of funding for Indian health programs. Together they supplement the dramatically inadequate direct funding from IHS, and help 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 and deductible have been rising steadily over the years: for 2023 the premium stands at \$164.90 per month for individuals earning \$97,000 or less per year, with much higher premiums for those earning more, and annual deductibles will be \$226. 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 AI/AN people enrolled in Medicare and associated premiums differently. Congress should exempt IHS beneficiaries from Medicare Part B premiums and deductibles.

Medicare Priority #1: Part B – Ensure parity in Medicare reimbursement for Indian Health Care Providers (Cost-sharing)

Chronic underfunding of IHS and Tribal facilities have resulted in significant economic disruption and loss of third-party revenues, including Medicare billing. The COVID-19 pandemic has exacerbated 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 are not generally able to bill AI/AN Medicare patients and routinely must waive the 20 percent patient copay. This means that as a 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 for their Medicare services 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 Language (Part A and Part B):

“(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.”

Medicare Priority #2 – Include Pharmacists Certified Community Health Aides and Practitioners (CHA/Ps), Behavioral Health Aides and Practitioners (BHA/Ps), and Dental Health Aide Therapists (DHATs) as eligible provider types under Medicare for reimbursement to IHS, Tribal health programs, and Urban Indian Organizations, for all Medicare-covered services that are within the scope of their licensed or certified practice under applicable State, federal, or tribal laws.

The TTAG was extremely pleased to see the provisions in the 2023 Consolidated Appropriations Act that, effective January 1, 2024, establish Medicare Part B coverage for Marital and Family Therapists (MFTs) and Mental Health Counselors (MHCs) and add them as qualified providers of Federally Qualified Health Center, Rural Health Clinic, and Hospice Program services for both Medicare and Medicaid. This will go a long way towards addressing the severe shortage of healthcare professionals and workers in Indian Country and throughout the Indian healthcare system.

We now ask Congress to build on that important step, by also establishing coverage for several other non-physician practitioners whose services are of particular importance to Indian Healthcare programs and their AI/AN patients, including Pharmacists, CHA/Ps, BHA/Ps, and DHATs.

These practitioners all receive rigorous training that equips them to furnish many of the same services that physicians, MFTs, MHCs, and other Medicare-recognized professionals do, and like them, they are subject to strict licensing, certification, ethical, and continuing education requirements. CHA/Ps are trained to provide primary and emergency health care services, and they are the only healthcare providers in dozens of remote Alaska Native communities. Higher-level BHA/Ps are qualified to furnish many of the same behavioral health services that MFTs and MHCs do. Pharmacists are professionally trained to furnish a wide array of related healthcare services beyond merely filling and dispensing medications; they play a vital role in many Indian health programs delivering, among other services, clinic-based and protocol-driven anticoagulation, tobacco cessation, cardiovascular risk reduction, and asthma/COPD stabilization services, as well as 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, and that Medicare covers when furnished by other provider types, 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. The failure to recognize and authorize Medicare payment for services furnished by these well-qualified providers perpetuates historic inequities experienced by AI/AN people, squanders the talents of these dedicated workers, and misses a meaningful opportunity to respond more fully to what the now nation-wide shortage of qualified health care workers. It is time for Congress to fully recognize the competency and capacity of these under-appreciated provider types, and to authorize Medicare reimbursement for all otherwise-covered Medicare services that they are qualified to furnish under applicable laws.

Legislative Language:

Adding Medicare Part B coverage for services of Indian Health Program Pharmacist and Certified Community Health Practitioner Services.

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

(JJ) Indian health program pharmacist and certified community practitioner services as defined in subsection (mmm).

--Section 1861 of the Social Security Act [42 U.S.C. 1395x] (Definitions) is amended by adding at the end the following new subsections:

(mmm) "INDIAN HEALTH PROGRAM PHARMACIST AND CERTIFIED COMMUNITY PRACTITIONER SERVICES; INDIAN HEALTH PROGRAM PHARMACIST AND CERTIFIED COMMUNITY PRACTITIONER. --

(1) "Indian health program pharmacist and certified community 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 pharmacist or certified community practitioner.

(2) "Indian health program pharmacist" means any individual licensed and in good standing as a pharmacist in any State, who furnishes services within the scope of that licensure 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).

(3) "Indian health program certified community practitioner" means any individual certified by and in good standing with a federally- or tribally-established Community Health Aide Program Certification Board, including but not limited to Community Health Aides and Practitioners, Behavioral Health Aides and Practitioners, and Dental Health Aide Therapists, , who furnishes services within the scope of that certification 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).

Adding Medicare and Medicaid Coverage for Services furnished in Certain Setting by Pharmacists and Certified Community Health Practitioners working in Indian Health Programs.

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS. —Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or by a mental health counselor (as defined in subsection (III)(4))” and inserting “, by a mental health counselor (as defined in subsection (III)(4), or by an Indian health program pharmacist or Indian health program certified community practitioner (as defined in subsection (mmm)).”

(2) HOSPICE PROGRAMS. —Section 1861(dd)(2)(B)(i)(III) of the Social Security Act (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by striking “or mental health counselor” and inserting “, mental health counselor, Indian health program pharmacist, or Indian health program certified community practitioner.”

Medicare Priority #3: 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

During the COVID-19 crisis, telehealth and telemedicine have been especially critical to providing health care services to AI/AN people. Unfortunately, rural tribal nations may be unable to provide these services due to the restrictions on Medicare telehealth and 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 2021 (H.R. 2903, S. 1512) and has the support of the American Medical Association and over 100 other organizations.

Title IV, Subtitle B, Section 4113 of the Consolidated Appropriations Act, 2023 extends certain Medicare telehealth flexibilities through at least December 31, 2024. Among other things, these allow individuals to receive telehealth services in their home; allow telehealth services to be provided by qualified occupational therapists, qualified speech-language pathologists, and qualified audiologists; expand the telehealth services that may be furnished by federally qualified health centers (FQHCs) and rural health clinics (RHCs); suspends of requirements for initial and periodic in person visits for mental telehealth services; and authorize audio only telehealth services.

Section 101 of the CONNECT to Health Act of 2021 would provide HHS with the ability to waive certain telehealth restrictions outside of the national emergency context. These waivable restrictions include limitations on originating sites, provider types, technology, geographic area, services, and any other telehealth limitation. Section 107 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 102–106, 108–109, and 303 of the CONNECT for Health Act affect use of telehealth

for emergency care, hospice care, RHCs and FQHCs; improve the process for adding services available via telehealth; remove geographic restrictions; allow waiver of restrictions during public health emergencies outside of the COVID-19 public health emergency; and 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 and beyond, tribal nations strongly recommend that Congress not only permanently extend the existing waiver authority for the use of telehealth under Medicare (Section 1834 of SSA), but to also enact certain sections of the CONNECT for Health Act.

CONNECT ACT - See Sections 101–109, and Section 303 of H.R. 2903 or S. 1512

Legislative Language:

Sec. 101. Expanding the use of telehealth through the waiver of requirements

(a) IN GENERAL.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(1) in paragraph (4)(C)(i), by striking “and (7)” and inserting “(7), and (9)”; and

(2) by adding at the end the following:

“(9) AUTHORITY TO WAIVE REQUIREMENTS AND LIMITATIONS.—

“(A) IN GENERAL.—Notwithstanding the preceding provisions of this subsection, in the case of telehealth services furnished on or after January 1, 2022, the Secretary may waive any requirement described in subparagraph (B) that is applicable to payment for telehealth services under this subsection, but only if the Secretary determines that such waiver would not adversely impact quality of care.

“(B) REQUIREMENTS DESCRIBED.—For purposes of this paragraph, requirements applicable to payment for telehealth services under this subsection are—

“(i) requirements relating to qualifications for an originating site under paragraph (4)(C)(ii);

“(ii) any geographic requirement under paragraph (4)(C)(i) (other than applicable State law requirements, including State licensure requirements);

“(iii) any limitation on the type of technology used to furnish telehealth services;

“(iv) any limitation on the types of practitioners who are eligible to furnish telehealth services (other than the requirement that the practitioner is enrolled under this title);

“(v) any limitation on specific services designated as telehealth services pursuant to this subsection (provided the Secretary determines that such services are clinically appropriate to furnish remotely); or

“(vi) any other limitation relating to the furnishing of telehealth services under this title identified by the Secretary.

“(C) WAIVER IMPLEMENTATION.—In implementing a waiver under this paragraph, the Secretary may establish parameters, as appropriate, for telehealth services under such waiver, including with respect to payment of a facility fee for originating sites and beneficiary and program integrity protections.

“(D) PUBLIC COMMENT.—The Secretary shall establish a process by which stakeholders may (on at least an annual basis) provide public comment on waivers under this paragraph.

“(E) PERIODIC REVIEW OF WAIVERS.—The Secretary shall periodically, but not more often than every 3 years, reassess each waiver under this paragraph to determine whether the waiver continues to meet the quality of care condition applicable under subparagraph (A). The Secretary shall terminate any waiver that does not continue to meet such condition.”.

(b) POSTING OF INFORMATION.—Not later than 2 years after the date on which a waiver under section 1834(m)(9) of the Social Security Act, as added by subsection (a), first becomes effective, and at least every 2 years thereafter, the Secretary of Health and Human Services shall post on the Internet website of the Centers for Medicare & Medicaid Services—

(1) the number of Medicare beneficiaries receiving telehealth services by reason of each waiver under such section;

(2) the impact of such waivers on expenditures and utilization under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); and

(3) other outcomes, as determined appropriate by the Secretary.

Sec. 102. Removing geographic requirements for telehealth services

Section 1834(m)(4)(C) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)), as amended by section 101, is amended—

(1) in clause (i), in the matter preceding subclause (I), by inserting “and clause (iii)” after “and (9)”; and

(2) by adding at the end the following new clause:

“(iii) REMOVAL OF GEOGRAPHIC REQUIREMENTS.—The geographic requirements described in clause (i) shall not apply with respect to telehealth services furnished on or after the date of the enactment of this clause.”.

Sec. 103. Expanding originating sites

(a) EXPANDING THE HOME AS AN ORIGINATING SITE.—Section 1834(m)(4)(C)(ii)(X) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)(X)) is amended to read as follows:

“(X) (aa) Prior to the date of enactment of the CONNECT for Health Act of 2021, the home of an individual but only for purposes of section 1881(b)(3)(B) or telehealth services described in paragraph (7).

“(bb) On or after such date of enactment, the home of an individual.”.

(b) ALLOWING ADDITIONAL ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclause:

“(XII) Any other site determined appropriate by the Secretary at which an eligible telehealth individual is located at the time a telehealth service is furnished via a telecommunications system.”.

(c) PARAMETERS FOR NEW ORIGINATING SITES.—Section 1834(m)(4)(C) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)), as amended by section 102, is amended by adding at the end the following new clause:

“(iv) REQUIREMENTS FOR NEW SITES.—

“(I) IN GENERAL.—The Secretary may establish requirements for the furnishing of telehealth services at sites described in clause (ii)(XII) to provide for beneficiary and program integrity protections.

“(II) CLARIFICATION.—Nothing in this clause shall be construed to preclude the Secretary from establishing requirements for other originating sites described in clause (ii)”.

(d) NO ORIGINATING SITE FACILITY FEE FOR NEW SITES.—Section 1834(m)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(2)(B)(ii)) is amended—

(1) in the heading, by striking “IF ORIGINATING SITE IS THE HOME” and inserting “FOR CERTAIN SITES”; and

(2) by striking “paragraph (4)(C)(ii)(X)” and inserting “subclause (X) or (XII) of paragraph (4)(C)”.

Sec. 104. Use of telehealth in emergency medical care

(a) IN GENERAL.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), as amended by sections 101 and 102, is amended—

(1) in paragraph (4)(C)(i), by striking “and (9)” and inserting “(9), and (10)”; and

(2) by adding at the end the following:

“(10) TREATMENT OF EMERGENCY MEDICAL CARE FURNISHED THROUGH TELEHEALTH.—The geographic requirements described in paragraph (4)(C)(i) (other than applicable State law requirements, including State licensure requirements) shall not apply with respect to telehealth services that are services for emergency medical care (as determined by the Secretary) furnished on or after January 1, 2022, to an eligible telehealth individual.”.

(b) **ADDITIONAL SERVICES.**—As part of the implementation of the amendments made by this section, the Secretary of Health and Human Services shall consider whether additional services should be added to the services specified in paragraph (4)(F)(i) of section 1834(m) of such Act (42 U.S.C. 1395m)) for authorized payment under paragraph (1) of such section.

Sec. 105. Improvements to the process for adding telehealth services.

(a) **REVIEW.**—The Secretary shall undertake a review of the process established pursuant to section 1834(m)(4)(F)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(F)(ii)), and based on the results of such review—

(1) implement revisions to the process so that the criteria to add services prioritizes, as appropriate, improved access to care through clinically appropriate telehealth services; and

(2) provide clarification on what requests to add telehealth services under such process should include.

(b) **TEMPORARY COVERAGE OF CERTAIN TELEHEALTH SERVICES.**—Section 1834(m)(4)(F) of the Social Security Act (42 U.S.C. 1395m(m)(4)(F)) is amended by adding at the end the following new clause:

“(iii) **TEMPORARY COVERAGE OF CERTAIN TELEHEALTH SERVICES.**—The Secretary may add services with a reasonable potential likelihood of clinical benefit and improved access to care when furnished via a telecommunications system (as determined by the Secretary) on a temporary basis to those specified in clause (i) for authorized payment under paragraph (1).”.

Sec. 106. Federally qualified health centers and rural health clinics.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), as amended by sections 101, 102, and 104, is amended—

(1) in paragraph (4)(C)(i), in the matter preceding subclause (I), by inserting “, (8)” after “(7)”; and

(2) in paragraph (8)—

(A) in the paragraph heading by inserting “AND AFTER” after “DURING”;

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting “and after such emergency period” after “1135(g)(1)(B)”;

(ii) in clause (ii), by striking “and” at the end;

(iii) by redesignating clause (iii) as clause (iv); and

(iv) by inserting after clause (ii) the following new clause:

“(iii) the geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to such a telehealth service; and”; and

(C) by striking subparagraph (B) and inserting the following:

“(B) PAYMENT.—

“(i) IN GENERAL.—A telehealth service furnished by a Federally qualified health center or a rural health clinic to an individual pursuant to this paragraph on or after the date of the enactment of this subparagraph shall be deemed to be so furnished to such individual as an outpatient of such clinic or facility (as applicable) for purposes of paragraph (1) or (3), respectively, of section 1861(aa) and payable as a Federally qualified health center service or rural health clinic service (as applicable) under the prospective payment system established under section 1834(o) or under section 1833(a)(3), respectively.

“(ii) TREATMENT OF COSTS FOR FQHC PPS CALCULATIONS AND RHC AIR CALCULATIONS.—Costs associated with the delivery of telehealth services by a Federally qualified health center or rural health clinic serving as a distant site pursuant to this paragraph shall be considered allowable costs for purposes of the prospective payment system established under section 1834(o) and any payment methodologies developed under section 1833(a)(3), as applicable.”.

Sec. 107. Native American health facilities.

(a) IN GENERAL.—Section 1834(m)(4)(C) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)), as amended by sections 101, 102, and 103, is amended—

(1) in clause (i), by striking “clause (iii)” and inserting “clauses (iii) and (v)”; and

(2) by adding at the end the following new clause:

“(v) NATIVE AMERICAN HEALTH FACILITIES.—With respect to telehealth services furnished on or after January 1, 2022, the originating site requirements described in clauses (i) and (ii) shall not apply with respect to a facility of the Indian Health Service, whether operated by such Service, or by an Indian tribe (as that term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) or a tribal organization (as that term is defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), or a facility of the Native Hawaiian health care systems authorized under the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11701 et seq.).”.

(b) NO ORIGINATING SITE FACILITY FEE FOR CERTAIN NATIVE AMERICAN FACILITIES.—Section 1834(m)(2)(B)(i) of the Social Security Act (42 U.S.C. 1395m(m)(2)(B)(i)) is amended, in the matter preceding subclause (I), by inserting “(other than an originating site that is only described in clause (v) of paragraph (4)(C), and does not meet the requirement for an originating site under clauses (i) and (ii) of such paragraph)” after “the originating site”.

Sec. 108. Waiver of telehealth requirements during public health emergencies.

Section 1135(g)(1) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (C)”; and

(2) by adding at the end the following new subparagraph:

“(C) EXCEPTION FOR WAIVER OF TELEHEALTH REQUIREMENTS DURING PUBLIC HEALTH EMERGENCIES.—For purposes of subsection (b)(8), in addition to the emergency period described in subparagraph (B), an ‘emergency area’ is a geographical area in which, and an ‘emergency period’ is the period during which, there exists a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.”.

Sec. 109. Use of telehealth in recertification for hospice care

(a) IN GENERAL.—Section 1814(a)(7)(D)(i)(II) of the Social Security Act (42 U.S.C. 1395f(a)(7)(D)(i)(II)) is amended by inserting “and after such emergency period” after “1135(g)(1)(B)”.

(b) GAO REPORT.—Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States shall submit a report to Congress evaluating the impact of the amendment made by subsection (a) on—

(1) the number and percentage of beneficiaries recertified for the Medicare hospice benefit at 180 days and for subsequent benefit periods;

(2) the appropriateness for hospice care of the patients recertified through the use of telehealth; and

(3) any other factors determined appropriate by the Comptroller General.

Sec. 303. Model to allow additional health professionals to furnish telehealth services

Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the end the following new clause:

“(xxviii) Allowing health professionals, such as those described in section 1819(b)(5)(G) or section 1861(l)(4)(B), who are enrolled under section 1866(j) and not otherwise eligible under section 1834(m) to furnish telehealth services to furnish such services.”.

Medicare Priority #4: 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 the population they serve. 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 hospitals serving AI/AN's. 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.

Legislative Language:

Medicare Priority #5: Ensure the Hospital Acquired Condition formula does not harm IHS/Tribal Hospitals (low-volume)

The Hospital Acquired Condition (HAC) Reduction Program is a financial incentive program established under Section 3008 of the Affordable Care Act. It is for IPPS hospitals to improve patient safety by applying a one percent payment reduction to hospitals that rank in the lowest performing percentage of all subsection (d) hospitals with respect to the occurrence of hospital-acquired conditions (HACs) that appear during an applicable hospital stay. These HACs are a group of reasonably-preventable conditions selected by CMS that patients did not have upon admission to a hospital, but which developed during the hospital stay.

The HAC program has three measures identified in the IPPS rule:

AHRQ Patient Safety Measures (Domain 1) weighted at 35%

- Patient safety indicators (PSI) PSI 90 composite measure (8 measures)

HAC Infections (Domain 2) is weighted at 65%

Payment adjustments will impact hospitals that rank among the lowest performing 25%.

The CDC formula that is utilized to calculate Standardized Infection Ratio (SIR) is: Divide the hospital's reported number of HAIs by a hospital's predicted number of HAIs. **A hospital's number of predicted HAIs must be greater than or equal to one in order to calculate an SIR.**

If a hospital has insufficient data (INS) which results in the CDC not calculating an SIR for this measure and does not calculate into the Domain 2 score or Total HAC score and results in the hospital having zero in Domain 2, Domain 1 is weighted at 100%, instead of 35%.

With national programs such as 'Target Zero,' 100,000 Lives, Campaign ZERO, etc. promoting and striving to reduce medical errors, hospital acquired conditions, etc. to zero it is unfortunate that a facility that achieves zero (0) hospital acquired infections would be removed from the Domain 2 weight.

The formula is erroneous in that it does not account or weight is not applied appropriately if your health facilities Domain 2 score is zero (0). Solutions would be to:

- Assign a score to a zero (0) rate, such as .0001, or
- Only apply the 35% weighted score to Domain 1, not the total of 100%

In 2015, Acting Administrator Andrew Slavitt wrote that CMS is working with CDC and others to evaluate an alternative analytic method that potentially could be used in the HAC Reduction program. Any changes to the scoring methodology would require CMS to do so through the rulemaking process.

Since then, numerous attempts have been made by TTAG and CMS staff to make accommodations for low-volume hospitals. However, these attempts have not accomplished the goal. The reason is that the formula developed by CDC is faulty and punishes low-volume hospitals. Congress should step in and require the CDC to revise its formula that more equitably accommodates the circumstances of Indian and other low-volume hospitals.

Legislative Language:

42 U.S.C. 1395ww(p)(2) is amended by adding the following at the end of subsection (2)(B)(ii):

In implementing this provision, the Secretary shall adapt its risk adjustment methodology so that low volume hospitals are able to have HAC infections weighted at 65 percent even if their predicted HAC infection rate is less than one.