



# Tribal Technical Advisory Group



## To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 50 F Street NW | Washington, DC 20001 | (202) 507-4070 | (202) 507-4071 fax

September 11, 2023

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

*Submitted via regulations.gov*

**Re: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program**

Dear Administrator Brooks-LaSure:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to provide a response to the Centers for Medicare and Medicaid Services (CMS) proposed rule, “Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program” (CMS-1784-P). We appreciate the intent of this rule and its focus on community health integration, dental and oral health, and the unique challenges of providing care in rural and underserved areas. The following comments and recommendations reflect the input of the TTAG, and we hope to continue to engage on these issues with the agency as it promulgates its final rulemaking.

### **Health Equity Preamble:**

Before providing insight into any policy, it is important we highlight the important context in which TTAG’s comments are offered, and which should inform CMS’s consideration of them: the deep inequities in this nation’s health care delivery system, and the Biden administration’s commitment and urgent effort to eliminate them. Over the last year the entire federal government, including CMS, has been working to respond to the President’s Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (EO 13985). For the first time, the federal government is taking a systematic approach to address equity issues.

Important to understand about health disparities is that AI/AN people were once one of the healthiest people on this continent, before colonialism and the U.S. policies of

termination, assimilation, and boarding schools caused an “intergenerational pattern of cultural and familial disruption”<sup>1</sup> that drive health disparities today. These drivers have manifested in some of the worst health disparities for AI/AN people, including disproportionate rates of infant and maternal mortality, cancer, cardiovascular disease, depression, and other behavioral health conditions.

The recent Department of the Interior Boarding School Report explains that “Native Americans continue to rank near the bottom of all Americans in terms of health, education, and employment. Many AI/ANs face unique challenges and harsh living conditions resulting from the United States having removed their tribes to locations without access to adequate resources and basic infrastructure upon which their tribal governments can foster thriving communities.” It is important to acknowledge that efforts to address these disparities are often complicated by culturally inappropriate interventions and an inadequate understanding of the historical effects of U.S. policies and ongoing trauma of AI/AN people. This history that is the root cause of the significant health disparities that affect AI/AN populations.

The TTAG has always taken the position that CMS has ample legal authority to undertake distinct policies and programs specifically focused on AI/AN beneficiaries and the Indian Health Service (IHS) programs that provide their care, because of their unique legal status under the U.S. Constitution and the duties owed by the federal government under its treaty and trust responsibilities to AI/ANs. Under established principles of Indian law, programs and policies that are specifically established for Indigenous people and organizations do not constitute prohibited race-based classifications; rather, they are based on the unique political relationship between the federal government and Indian Tribes.

This unique legal relationship, taken together with EO 13985 and CMS’ Framework for Health Equity, provides a sound basis for CMS to adopt the TTAG recommendations on this proposed rule. We trust you will agree that the TTAG recommendations are directly related to CMS’ Framework discussed in “Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps.” The TTAG’s recommendations fit clearly within the intended outcomes of this chapter of the Framework as well as other priority areas of the Framework.

#### **Comments and Recommendations:**

##### **I. Include Community Health Aides and Community Health Representatives in the Community Health Integration Plan to Address Health-Related Social Needs**

We support the proposal for coding and payment changes to better account for resources involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel. These proposed services are aligned with the HHS Social Determinants of Health Action Plan. We also support the proposed coding and payment for SDOH risk assessments to recognize when practitioners spend time and resources assessing SDOH that may be impacting their ability to treat the

patient. We support and appreciate the addition of the SDOH risk assessment to the annual wellness visit as an optional element with a corresponding, additional payment. However, we ask that CMS consider including the SDOH risk assessment as a requirement or standard part of the annual wellness visit instead of optional. This may be the only opportunity to identify and resolve SDOH needs as well as barriers/challenges among patients (including low-income, less educated, and underinsured populations) that routinely miss appointments but may be able to comply with annual wellness visits.

In addition, the TTAG appreciates the proposal by CMS to better account for the resources involved in furnishing the important patient-centered care involving multidisciplinary teams of clinic staff and auxiliary personnel. The TTAG would like to ensure that community health workers that serve our communities are included and reimbursable in the Medicare community health integration proposed plan. To adequately care for our people, Indian Country has developed types of community-level care providers to address community needs: community health representatives (CHR) and Community Health Aide Program (CHAP) workers. The CHAP program is a multidisciplinary system of mid-level behavioral, community, and dental health professionals working alongside licensed providers to offer patients increased access to quality care in rural areas. We request that CMS reimburse for both of these provider types – CHR and CHAP personnel – which are both integral in Indian Country in providing care in our Tribal communities.

## **II. Caregiver Training Services**

We support the proposal to make payment when practitioners train and involve caregivers to support patients with certain diseases or illnesses when carrying out a treatment plan. While CMS is proposing to pay for these services when furnished by a physician or a non-physician practitioner (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists) or therapist (physical therapist, occupational therapist, or speech language pathologist) under an individualized treatment plan or therapy plan of care, we believe this list of practitioners should be expanded. To advance the recent Biden-Harris administration Executive Order on Increasing Access to High Quality Care and Supporting Caregivers, and to help support care by better training caregivers, the agency should seriously consider the range of practitioners included here.

## **III. Telehealth Services**

As you well know, telehealth services – both audiovisual and audio-only – have enabled individuals in rural and underserved areas to have improved access to care. Telehealth is a critical vehicle for achieving health equity for patients in communities that have long struggled to access behavioral health treatment, including but not limited to many of our Tribal nations. We appreciate CMS recognizing that any reversion to a lower rate for telehealth services to patients in their homes will lead practitioners to offer telehealth less frequently, and therefore we support the proposed rule preserving current

reimbursement rates for telehealth services. We urge CMS to further extend and preserve these rates past the extensions established in the Consolidated Appropriations Act (CAA) of 2023.

Our Tribal leadership appreciates the agency's proposal to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through December 31, 2024, but we encourage CMS to make this permanent.

#### **IV. Rural Health Clinics and Federally Qualified Health Centers**

TTAG leadership supports the extension of payment for telehealth services furnished in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) through December 31, 2024, and the delay of the in-person requirements under Medicare for mental health visits furnished by RHCs and FQHCs. Further, we appreciate CMS including licensed marriage and family therapists (LMFTs) and mental health counselors (MHCs) as eligible for payment.

TTAG supports the proposal to change the required level of supervision for behavioral health services furnished "incident to" a physician or nonphysician practitioners' (NPP) services in RHCs and FQHCs to allow general supervision, rather than direct supervision, consistent with the policies finalized under the PFS during last year's rulemaking for other settings.

#### **V. Dental and Oral Health Services**

TTAG supports the payment for dental services inextricably linked to, and substantially related to the clinical success of, specific covered medical services. But to enable us to provide the widest range of services to our people, who as a group suffer the lowest health status in the nation, we encourage the agency, when it considers whether to add a proposed scenario to the list of dental services that will qualify for payment, to adopt the broadest possible interpretation of what constitutes a "clinically significant" improvement in quality and safety outcomes, and of whether a dental service is "clinically meaningful" and results in "a material difference in ... clinical outcomes and success."

With more untreated tooth decay and periodontal disease than any other population group, the state of oral health among AI/AN people is alarming. AI/AN dental adult patients are more than twice as likely to have untreated decay compared to the general U.S. population, with 59 percent of adults over age 65 having untreated decay.<sup>1</sup> Of the AI/AN dental patients aged 40-64 years of age, 83 percent had teeth pulled because of tooth decay or gum disease compared to the national average of 66 percent.<sup>2</sup> AI/AN

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<sup>1</sup> Kathy R. Phipps, Dr.P.H. and Timothy L. Ricks, D.M.D., M.P.H., The Oral Health of American Indian and Alaska Native Adult Dental Patients: Results of the 2015 IHS Oral Health Survey, Indian Health Service Data Brief March 2016, [https://www.ihs.gov/doh/documents/IHS\\_Data\\_Brief\\_March\\_2016\\_Oral\\_Health%20Survey\\_35\\_plus.pdf](https://www.ihs.gov/doh/documents/IHS_Data_Brief_March_2016_Oral_Health%20Survey_35_plus.pdf).

<sup>2</sup> *Id.*

people are more likely to report poor oral health, oral pain, and food avoidance than the general U.S. population.<sup>3</sup>

Some medical scenarios where dental services (examinations, extractions, root canals, and any other necessary dental procedure) should be covered, include for cardiac patients, diabetic patients, and patients seeking in-patient treatment for a substance use disorder as dental services may be inextricably linked to the success of their treatment program. Accessible dental care is important to preventing dental disease and keeping people healthy: it is an essential piece of health care.

**Conclusion:**

TTAG leadership deeply appreciates your consideration of the above comments and recommendations and look forward to engaging with the agency further.

Sincerely,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is fluid and cursive, with the first name "W." and last name "Allen" clearly visible.

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

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<sup>3</sup> *Id.*