



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

July 9, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS Tribal Technical Advisory Group Priorities

Dear Administrator Oz:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), we submit our 2025 CMS TTAG priorities. The full TTAG membership formally adopted these priorities during a special meeting held on July 3, 2025.

As you know, TTAG serves as an advisory body to CMS, providing expertise on policies, guidelines, and programmatic issues affecting the delivery of health care to American Indians and Alaska Natives (AI/ANs) served by Medicare, Medicaid, CHIP, CCIIO and other CMS-funded health care programs. The attached TTAG Medicare and Medicaid policy and legislative priorities offer a roadmap for CMS to address health equity within the Indian health system.

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

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, the agency can support this effort by providing Congress with thorough and timely technical assistance on any proposed legislation related to the TTAG priorities.

TTAG first submitted our priorities to CMS in March of 2023. Since then, the TTAG Policy Subcommittee and CMS subject matter experts have formed small workgroups focused on each of the policy priorities to discuss the next steps in moving these priorities forward. This collaborative process has proven highly effective, resulting in CMS and TTAG accomplishing several major policy priorities. TTAG respectfully requests this successful process be continued in our work toward the accomplishment of these 2025 priorities.

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,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is written in a cursive style with a large, stylized "W" and "A".

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



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

CMS TTAG Medicare and Medicaid Policy and Legislative Priorities

July 2025

MEDICAID POLICY PRIORITIES

Medicaid Policy Priority #1: Shield Indian Health Care Providers from state benefit cuts or enrollment limitations

TTAG is concerned that some States are cutting their Medicaid program benefits and enrollment rates through program limitations, work requirements, and increased administrative complexity as the nation considers Medicaid reform initiatives. Even though States receive 100 percent Federal Medical Assistance Percentage (FMAP) for Medicaid services furnished by Indian health care providers (IHCP) to Indian Health Service (IHS) beneficiaries, they generally cover tribal programs and American Indian/Alaska Native (AI/AN) patients 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. ***TTAG requests 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.

Medicaid Policy Priority #2: CMS enforcement of state compliance in the administration of Medicaid Managed Care (special protections for AI/AN enrollees and IHCPs, claims processing, paying the OMB Encounter Rate where appropriate)

On May 6, 2016, CMS issued a final rule entitled Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability (42 CFR 438.14).

On December 14, 2016, CMCS released an Informational Bulletin entitled Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations outlines the special protections and provisions for AI/AN enrollees into Medicaid.

The final rule codifies a range of Indian managed care protections, including those in section 1932(h) of the Social Security Act (Act), as added by section 5006 of American Recovery and Reinvestment Act of 2009 (ARRA). These provisions allow Indians enrolled in Medicaid and CHIP managed care plans to continue to receive services from an IHCP and ensures IHCPs are reimbursed appropriately for services provided.

The final rule addresses other Tribal issues, such as sufficient network and payment requirements for managed care plans that serve Indians, network provider agreements with IHCPs, state-Tribal consultation requirements, and referrals and prior authorization requirements. The Indian-specific provisions are located in the Medicaid rules at §438.14, and made applicable in CHIP by a cross reference in the CHIP rules at §457.1209. They are titled: “Standards for Contracts Involving Indians, Indian Health Care Providers and Indian Managed Care Entities.” These provisions must be implemented for Medicaid managed care plans by the start of the rating period for contracts starting on or after July 1, 2017, noting that the Indian managed care protections in 1932(h) were effective July 1, 2009. (The rating period is the 12-month contract period during which a particular rate is certified.) States with separate CHIP programs that have plans that contract separately from their Medicaid managed care plans were required to come into compliance with these provisions no later than the state fiscal year beginning on or after July 1, 2018.

In light of these regulations, there continue to be state level issues with AI/AN enrollment and compensation. ***TTAG requests CMS monitor state managed care plans to ensure proper compliance with all regulations.*** In particular, tribes in states with managed care plans continue to struggle with receiving the OMB encounter rate from managed care organizations because of technical difficulties in claims processing, lack of understanding of the unique nature of the IHS and Tribal Health systems, and failure to understand and implement the Indian Addendum to contracts. The increased administrative complexity of working with multiple Medicaid managed care plans places an undue burden on Tribes, and delays in timely and appropriate compensation for services rendered create cash flow challenges for Tribal clinics.

Medicaid Policy Priority #3: 431.12 CFR rule – Medicaid Advisory Committee - Beneficiary Advisory Council - create requirement to include Tribal representatives on the state Committees

On April 22, 2024 CMS released the Ensuring Access and Eligibility in Medicaid final rule (431.12 CFR rule), which aims to advance health care access and quality, and improve health outcomes for all Medicaid members. The new rule fundamentally shifts state requirements for convening Medicaid member advisory groups, elevating the central role members should play in shaping Medicaid program and policy changes. The two advisory groups will ensure Medicaid members’

priorities are fully understood and reflected in Medicaid programs and policies and center lived experience and perspectives of Medicaid members in decision-making processes.

For over 40 years, CMS required states to convene Medical Care Advisory Committees (MCACs) to advise their Medicaid agencies on health and medical care services. The lack of specificity in these rules, however, has led to significant variability across state MCACs. For example, MCACs vary widely in their meeting frequency, structure, governance, accountability, and transparency. Further, the narrow focus for MCACs on solely health and medical topics ignores many aspects of the Medicaid program that members may want to discuss, for example, health-related social needs, barriers to accessing care, and benefits eligibility challenges.

The new rule includes the following important changes:

1. Rename the MCAC to the Medicaid Advisory Committee (MAC), and expand the scope of purpose of the committee;
2. Require states to establish a Beneficiary Advisory Council (BAC);
3. Establish minimum requirements for Medicaid member representation on the MAC;
4. Promote transparency and accountability of the MAC and BAC through the public reporting of membership, meeting materials, bylaws, and attendance; and
5. Require states to develop public-facing annual reports on MAC and BAC activities.

States will be required to establish both the MAC and BAC within one year of the final rule effective date of July 9, 2024. States must hold meetings and publish a required annual report by the end of the following year.

The AI/AN population have unique needs and special protections and should be included in this decision-making process. To accomplish that, ***TTAG requests CMS to revise the rule and include a representative from the state's tribal health care providers.***

Medicaid Policy Priority #4: Advocate for the National Association of Medicaid Directors to create a Tribal Subcommittee

The National Association of Medicaid Directors (NAMD) elevates and supports Medicaid leaders so millions of people can achieve their best health. The association is governed by Medicaid Directors from across the country. They are supported by a team of subject matter experts focused on federal policy, state program support and leadership development. Their mission is to help millions of people served by Medicaid by representing, elevating, and supporting state and territorial Medicaid and CHIP leaders in connecting eligible people to coverage, promoting access to care, providing high value services, and controlling program costs for sustainability.

TTAG requests increased state-Tribal engagement on Indian health and Medicaid by establishing a NAMD-TTAG workgroup. This workgroup will consist of members from TTAG, NAMD, and CMS Division of Tribal Affairs. The goal of this workgroup is to facilitate open and transparent communication between states and Tribes, increase collaboration on challenging Indian health policy and Medicaid issues, and develop relationships.

MEDICARE POLICY PRIORITIES

Medicare Policy Priority #1: Make IHS Outpatient Encounter Rate Available to all Indian Outpatient Programs

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. ***TTAG requests CMS 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 OMB-approved Outpatient encounter rate, and without irrelevant or additional cost-reporting requirements.***

Medicare Policy Priority #2: Part C, Issue 1 - Payment by Medicare Advantage Plans at OMB Encounter Rate

Medicare Advantage (MA) plans are not reimbursing Indian health care providers at the OMB encounter rates, and often refusing to reimburse at all. ***TTAG requests CMS 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 IHClA (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 encounter 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 Policy Priority #2: Part C, Issue 2 – Provide Education to Medicare Advantage Plans to Prevent Predatory Enrollment Practices

Some MAPs have targeted Tribal citizens for plan enrollment, using predatory practices to entice them – and then not paying IHS and Tribal providers. Insurance companies meet with Tribal citizens, sometimes at Tribal senior citizen centers, to tout the benefits of enrolling in MAPs. However, enrollment in the MAPs is disruptive to Indian Health providers. Most Indian Health providers are not contracted providers under MAPs, and so the plans do not pay the IHS/Tribal facilities. In addition, Indian Health Providers not contracted to MAPs 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 IHS and Tribal facilities would be impacted if they enroll into a Medicare Advantage plan. ***TTAG request CMS to develop relevant materials, including but not limited to, information sheets or FAQ's that clarify these issues and require usage by all Part C plans and brokers.***

Medicare Policy Priority #3: Revise and expand the Medicare Part D Indian Addendum to cover all issuers, including Patient Benefit Managers and prohibit reduction in reimbursements due to accessing discount pharmaceutical programs

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 developed a new Part D Indian Addendum that would address these issues and requests CMS adopt it. TTAG requests IHS and CMS develop a joint document to serve as an updated IHS Creditable Coverage Letter for Medicare Part D.***

Medicare Policy Priority #4: Exempt IHS/Tribal/Urban 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 providers to limit services to IHS beneficiaries. ***TTAG requests an exemption from the competitive bidding process to allow Indian health care providers to access and bill for DME.***

Medicare Policy Priority #5: Increase Flexibility in Medicare Definition of Telemedicine Services and reinstate OMB encounter rate for off-site telemedicine visits

The most recent public health emergency made it necessary for the Medicare program to cover more telehealth services to allow access to providers. 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 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.

The Medicare telehealth flexibilities were extended through FY2024 in the FY2023 Omnibus bill. ***TTAG is requesting CMS make these flexibilities permanent and provide maximum flexibility in the implementation.*** During the public health emergency, CMS ensured payment for telemedicine visits was the same as in-person visits. ***TTAG request CMS to ensure telemedicine services are reimbursed at the same rate as in-person services.***

MEDICAID LEGISLATIVE PRIORITIES

Medicaid Legislative Priority #1: Authorize Medicaid reimbursement 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 AI/ANs. In order to ensure that States not bear the increased costs associated with allowing IHCPs access to Medicaid resources, Congress provided that the United States would pay 100 percent of the costs for services received through Tribal and IHS providers (100 percent FMAP). While Congress provided equal access to the Medicaid

program to all IHCPs, 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, ***TTAG request Congress authorize IHCPs 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 Indian Health Care Improvement Act (IHCIA) when delivered to Medicaid-eligible AI/ANs. This would allow all IHCPs 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 (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. 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 Legislative Priority #2: 100% FMAP for Urban Indian Organizations

Congress provided for 100% FMAP reimbursement for services provided to AI/ANs through Urban Indian Organizations (UIO) but that authorization was temporary and expired in March 2023. ***TTAG requests that Congress enact new legislation to permanently extend 100% FMAP to services furnished by UIOs.***

Legislative Language

SEC. 1. 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.”

MEDICARE LEGISLATIVE PRIORITIES

Medicare Legislative Priority #1: Issue 1 - Eliminate Medicare Part B Premiums and Deductibles for IHS beneficiaries and ensure full Medicare reimbursement for IHCPs

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 2025 the premium stands at \$185.00 per month for individuals earning \$106,000 or less per year, with much higher premiums for those earning more, and annual deductibles will be \$257.00. 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. ***TTAG requests Congress exempt IHS beneficiaries from Medicare Part B premiums and deductibles.***

Medicare Legislative Priority #1: Issue 2 - 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. Unlike other Medicare providers, IHCPs are not generally able to collect co-pays and deductibles from AI/AN Medicare patients. This means that as a rule, IHCPs 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. ***TTAG requests Congress to adopt legislation to ensure that the United States reimburses IHCPs 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 (Issue 1 and Issue 2)

"(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 Legislative Priority #2: Permanently expand Medicare telehealth reimbursement for IHCPs

During the recent public health emergency, 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. The public health emergency dramatically increased the need to connect Medicare patients to their providers through telehealth. This increased need continued after the public health emergency 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.

To this end, the Coronavirus Preparedness and Response Supplemental Appropriations Act provided the Secretary of HHS with the ability to waive telehealth restrictions during public health 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 2025 (S. 1261) and has the support of the American Medical Association and over 150 other organizations.

Since the public health emergency, Congress has repeatedly extended the Medicare telehealth flexibility on a piecemeal basis, usually through annual appropriations or continuing resolutions. 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 and TTAG requests 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”;

(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 Legislative Priority #3: Expand Medicare services and provider types to include Long Term Care

Medicare does not generally cover full time long term care in a skilled nursing facility or in the home. Medicare Part A covers limited skilled nursing facility care on a short-term basis under certain conditions. The Medicare beneficiary must have a qualifying inpatient hospital stay of at least 3 days in a row, enter the SNF within a short time of leaving the hospital (generally 30 days), require skilled services to improve or maintain current condition or to prevent or delay it from getting worse. Medicare does not pay for 24-hour a day care at home, home meal delivery, homemaker services unrelated to care plan, custodial or personal care that helps with activities of daily living (like bathing, dressing, using the bathroom). ***TTAG requests that Congress amend the Social Security Act to allow Medicare reimbursement for long term care for Indian health care providers.***

Medicare Legislative Priority #4: Authorize new Tribal Medicare provider types to include Pharmacists, Certified Community Health Aides and Practitioners (CHA/Ps), Behavioral Health Aides and Practitioners (BHA/Ps), and Dental Health Aide Therapists (DHATs)

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. ***TTAG 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 1861of 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.”

Indian Safe Harbor to Anti-Kickback Statute Priority

Since 2012, 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. 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. ***TTAG requests the HHS OIG approve its request for an Indian-specific safe harbor to the Anti-Kickback Statute.***

Legislative Language

SEC. ---. PROVIDING ANTI-KICKBACK SAFE HARBOR FOR INDIAN HEALTH CARE PROVIDERS

(a) IN GENERAL.—Section 1125B(b)(3) (42 U.S.C. 1320a-7b(b)(3)), is amended--

(1) in subparagraph (b)(3)(L)(4), by striking the period at the end and inserting “; and” and

(2) by adding at the end, the following new subparagraph
“(M) any remuneration between (1) a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603) and (2) any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health care program pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, expand the scope or type, or enhance the quality, of services provided by the health care program.”.

(b) Rulemaking for Exception for Indian Health Care Providers

(1) IN GENERAL.—The Secretary shall establish, on an expedited basis, standards relating to the exception described in subsection (a).

(2) DEADLINE.—Not later than 1 year after the date of the enactment of this Act the Secretary shall publish final regulations establishing the standards described in paragraph (1)