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MEMORANDUM

March 22, 2021

TO: Tribal Health Clients

FROM: Hobbs, Straus, Dean & Walker, LLP

RE: ***TTAG and MMPC Quarterly Meeting Report***

The Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) recently met virtually with CMS leadership teams to discuss Medicare and Medicaid policies and programs impacting Indian Country, as well as the national COVID-19 response and recovery. The CMS Medicare/Medicaid Policy Committee (MMPC) met virtually the day before to prepare for the TTAG Meeting. This report provides a summary of the major topics raised during these meetings.

I. Meeting with CMS Leadership

The Biden Administration has nominated Chiquita Brooks-LaSure to be director of CMS, but she has not yet been confirmed. In her place CMS leadership was represented by Liz Richter, Acting Administrator; Jeff Wu, Principal Deputy Administrator for Operations; and Anne Marie Costello, Acting Deputy Administrator and Director of the Center for Medicaid and CHIP Services (CMCS). Ms. Richter said she was excited to work with the TTAG in her both acting role and in her role with the Medicare program, and she highlighted HHS's tribal consultation initiative.

TTAG Chairman Ron Allen, Jamestown S'Klallam Tribe, said the TTAG was eager to begin work with the new Administration and hoped the TTAG could make progress on its priority issues. Melissa Gower, who chairs the TTAG Policy Subcommittee, provided a summary of the TTAG's current priority issues, which include:

Medicare Issues:

- Increase reimbursement to tribal hospitals for COVID-19 testing.
- Update Chapter 19 of the Medicare Claims Processing Manual with the TTAG.
- Create an IHS/tribal accommodation under hospital acquired condition rules.
- Increase flexibility in Medicare definition of telemedicine services.
- Ensure Medicare Advantage plans pay Medicare Part C at the OMB rate.
- Address Medicare Part D reimbursement (tribal facilities across the country are getting hit with steep reimbursements discounts from pharmacy benefit managers).
- Allow direct sponsorship of Part B premiums by Indian health programs.
- Make the IHS outpatient encounter rate available to all Indian outpatient programs

that request it (and permanently fix the grandfathered tribal provider FQHC issue).
- Provide Medicare Part B penalty relief for Native elders for delayed enrollment.
- Support community education to prevent predatory Medicare Advantage enrollment practices that some plans practice.
- Exempt IHS hospitals from the hospital star rating system.
- Ensure Indian Health Care Providers (IHCPs) that continue to use the RPMS can obtain hardship exemptions.
- Exempt IHS, tribal, and urban Indian health program (I/T/U) durable medical equipment suppliers from competitive bidding processes.

Medicaid Issues:
- Encourage States to increase Medicaid telehealth reimbursement for IHCPs.
- Issue Medicaid State Health Official letter to managed care organizations to enforce the Indian provisions of Medicaid managed care.
- Shield IHCPs from State benefit cuts or enrollment limitations.

TTAG told CMS that it was going to circulate these issues as a "living" chart so that we can track progress on addressing all of these from meeting to meeting. TTAG also briefly addressed the new premium subsidies being made available for the Affordable Care Act (ACA) marketplace exchanges and the need to consult with tribes on any regulations to implement them. Jeffrey Wu stated that CMS does not plan to make any changes to its regulations to implement this change. Because it involves funding for premiums, the regulatory changes will be made by the Treasury Department rather than HHS.

II. HHS Tribal Consultation

As previously reported, President Biden issued an Executive Memorandum directing all federal agencies to review and improve their tribal consultation policies. Devin Delrow, Associate Director for Tribal Affairs with HHS Intergovernmental and External Affairs, provided an overview of the Memorandum and HHS implementation process. TTAG expressed appreciation for discussing the issue, but noted that conferring with TTAG is not a substitute for tribal consultation. They asked that all of HHS's operating divisions issue Dear Tribal Leader letters asking for input on tribal consultation.

III. Telehealth Issues

CMS presented a panel of five telehealth experts to meet with the TTAG. Emily Yoder, Division of Practitioner Services, provided an overview of CMS's Medicare telehealth rules, the flexibilities available during the Public Health Emergency, and Medicare's recent final rule expanding telehealth. Ms. Yoder summarized the existing Medicare telehealth rule under Section 1834(m) of the Social Security Act. That statute requires that Medicare telehealth services be provided only when a patient is physically present in a clinic (called the originating site) and receives telehealth services from a specialist at a distant site. It applies only to rural areas and must involve the use of interactive telecommunications devices, not just a telephone. Under the regular Medicare telehealth rules, the specialist at the distant site is able to bill Medicare for the

service, while the originating site gets a flat fee. Ms. Yoder noted, however, that certain services not provided by a physician or practitioner are not subject to these limitations, including certain care management services, communication technology based services and remote physiological monitoring.

During the Public Health Emergency, Medicare has lifted the originating and distant site restrictions, among others. Ms. Yoder confirmed these new flexibilities will continue to run until two months after the expiration of the Public Health Emergency, which is expected to run at least until the end of the year. Ms. Yoder also provided an overview of the Medicare telehealth flexibilities being made permanent in the 2021 Medicare Physician Fee Schedule Final Rule

William England, Senior Advisor in the Federal Office of Rural Health Policy, provided an overview of the Health Resources and Services Administration's (HRSA) numerous telehealth initiatives. HRSA funds telehealth through a variety of grant and other funding opportunities with increases in recent years, including the receipt of $54.6 million in COVID-related telehealth funding. Mr. England said that HRSA supports telehealth resource centers, including ones dedicated to telehealth policy and technology, across the country. He also highlighted the $1 billion in tribal broadband funding made available by the 2021 Omnibus Appropriations Act. While that funding is being made available through the Commerce Department, they have been consulting with HRSA to create the grant program. Mr. England estimated that the $1 billion Tribal Broadband Connectivity Grant program grants would be open by early summer.

Matthew Quinn, Science Director of the Army's Telemedicine and Advance Technology Research Center, provided an overview of the National Emergency Tele-Critical Care Network that the Army developed to help address COVID-19. It is a free product that connects frontline clinicians with teams of specialists to provide 24/7 support. Generally speaking, it is available on a short-term basis to provide frontline healthcare workers with critically needed support. For more information, please go to https://www.tatrc.org/netccn/.

Finally, Dr. Barry Marx, Office of Clinician Engagement, provided an over of his office's work to train providers on telehealth best practices.

Chairman Allen stressed the importance of telehealth for tribal communities both during the Public Health Emergency and after. He asked that all of the current telehealth flexibilities be made permanent to the maximum extent possible. Melissa Gower reiterated that point, noting that Section 1834(m) imposes unduly burdensome originating and distant site requirements that prevent telehealth services from being provided in a patient's home where it is needed. She asked that CMS support legislative changes that would lift these burdens after the Public Health Emergency is ended. Chairman Allen also asked that telehealth services be adequately reimbursed at the same rate as in-person services.

With HRSA, TTAG stressed the fact that without funding for necessary infrastructure, telehealth cannot occur. They noted that tribal populations are mostly located in rural areas where telehealth is a necessity. They asked that HRSA, to the maximum extent possible, make telehealth infrastructure available to tribes through non-competitive grant processes and dedicated set asides.

IV. Four Walls Issue

TTAG brought up the four walls issue with CMS leadership and with Kitty Marx and the CMS Tribal Affairs team. They thanked CMS for extending the grace period. CMS had extended it to give certain States more time to create tribal Medicaid FQHC workarounds for the four walls limitation. TTAG recognized that but asked whether, given the additional grace period, CMS would reexamine the underlying policy that led to the four walls issue. Ms. Marx said she would take the request back and that a reexamination might be possible under the new administration.

V. Hospital Acquired Conditions (HAC) Reduction Program

Lt. Commander Jennifer Tate, Center for Clinical Standards and Quality, provided an update on the HAC Reduction Program – a program that unfairly targets IHS and tribal hospitals, as well as other rural low volume hospitals. It requires hospitals to report instances of certain hospital acquired conditions, which are used as one of the measurements in the hospital star rating system. CMS then identifies and publishes a list of the 25% worst-performing hospitals in the country. IHS and tribal hospitals are often on that list because the formula used with the Program does not account for low patient volume. TTAG has been working on this issue for several years.

Ms. Tate did not have a solution to propose to the TTAG, but her presentation demonstrated just how unfair the formula is to IHS and tribal hospitals. She went through some examples that showed that if a hospital's predicted number of secondary infections is less than one and a hospital has a single incidence of secondary infection, that hospital would be in the lowest 25% of hospitals. In that case, a single incidence would trigger the finding, even though larger hospitals with many more incidences would not. While Ms. Tate did not explicitly say so, her presentation appeared to suggest that hospitals could improve their performance by submitting data correctly.

Data submission is not the issue, however. Melanie Fourkiller pointed out that a difference between the predicted rate and the actual rate can skew an IHS or tribal hospital's score. She added that tribal populations, on average, have poorer health outcomes than the general population, which results in longer hospital stays and the concomitant increased risk of hospital acquired conditions. TTAG also pointed out that inaccurately scoring IHS and tribal hospitals increases patient reluctance to seek needed care. TTAG requested that CMS change the formula and exempt IHS and tribal hospitals from the program.

VI. Office of Minority Health and Rural Health

TTAG met with Dr. LaShawn McIver, Director of the CMS Office of Minority Health. The mission of that office is to reduce health disparities in minority communities. Dr. McIver summarized President Biden's Executive Order 13985: Advancing Racial Equity and Support for Underserved Communities through the Federal Government that requires federal agencies to address racial equity for underserved communities, including tribal communities. She also summarized CMS's existing work on racial equity, including CMS's Equity Plan for Medicare.

TTAG Member Dr. Judy GoForth Parker, Chickasaw Nation, stated that lack of health equity continues to be a big issue for Indian Country and that tribal communities have been

disproportionately impacted by COVID-19. She stressed, however, that in addition to being an underserved community, tribes are sovereign governments and the United States has trust obligations to serve their members. She noted that any health equity initiative must include consultation with tribes.

Darci Graves, Co-Chair of the Office of Minority Health and Rural Health Council, provided an overview of CMS's Rural Health Initiative. Among other goals, the initiative endeavors to apply a rural lens to CMS priorities and improve telehealth and telemedicine. She noted that according to CMS data, 29% of rural tribal populations report poor health, which is about the same as Black and Hispanic adults. She reported that CMS is looking at issues involving rural bypass of local health facilities.

VII. Other Issues

Family Enrollment in ACA Plans. AI/ANs are entitled to enroll in AI/AN specific plans on the Affordable Care Act marketplace that eliminate cost-sharing for them under the plans. These benefits only apply to Tribal members, however. Some families have both members and non-members. If a tribal member enrolls in a family plan with non-members, they cannot take advantage of the special zero and limited cost sharing plans for AI/ANs. Lisa Rashid of CCIIO announced that CCIIO had updated its ACA Marketplace website to give tribal members this information and to encourage them to enroll in limited or zero cost sharing plans instead.

Office of Inspector General (OIG) IHCP Safe Harbor Request. Elliott Milhollin, TTAG Technical Advisor with our office, provided an update on TTAG's multi-year effort to establish a safe harbor for IHCPs from the Anti-Kickback Statute and Civil Monetary Penalty rules regarding beneficiary inducements. He reported that OIG extended the deadline for proposing a safe harbor from February 16 to April 2, 2021. TTAG refined and resubmitted its 2019 proposal to provide greater clarity to IHCPs on acceptable practices, and it is in the process of follow-up on that action with additional communications before the April deadline.

IHCIA State Professional Licensing Exemption. MMPC discussed the potential extension of the Indian Health Care Improvement Act's exemption from State professional licensing requirements to all professionals furnishing services for a tribal health program. Section 221 currently limits the exemption to health professionals "employed by" a tribal health program. Kay Gouwens, Sonosky Chambers, explained that the limitation has been a significant challenge in Alaska and likely elsewhere in Indian Country, particularly in regard to professional serving at a site through an agency, personal services contract, or other entity. She stated that expanding the exemption, which would require Congressional action, would address this issue and also facilitate telehealth services where State licensing requirements may limit the treatment of patients across State lines. State licensing requirements are separate from State Medicaid authorities. MMPC explored whether a national steering committee should be convened to provide timely reviews and recommendations on future IHCIA amendments.

Medicare Part D Special Enrollment Period Request. MMPC discussed the need for a special enrollment period to facilitate the enrollment of Native elders into Medicare Part D. MMPC reported that it has received notifications from certain tribes of elders that have missed the

annual enrollment deadline due to extenuating circumstances that now place their access to affordable drug coverage at risk. They had been informed by a Medicare Native American Contact that a special enrollment period would only be available in areas with a large impacted population.

Veterans Affairs (VA) Care Coordination. Melanie Fourkiller reported that the VA is working with the IHS on implementation of the "PRC for Native Veterans Act" and the elimination of co-pays for Native veterans within the VA health system. John Rael, Director of the IHS Office of Resource Access and Partnerships, stated that the agencies have had a single coordinating call thus far in which they discussed the challenges associated with existing third-party billing services for PRC. Ms. Fourkiller stressed the need for a process of assuring the correct PRC billing rate that does not become overly burdensome to administer.

Conclusion

The next MMPC and TTAG meetings will take place in July 2021. If you have any questions or would like information on any of issues raised in this report, please do not hesitate to contact Elliott Milhollin (emilhollin@hobbsstraus.com or 202-822-8282); Geoff Strommer (gstrommer@hobbsstraus.com or 503-242-1745) or Lisa Meissner (lmeissner@hobbsstraus.com or 202-822-8282).