

CMS TTAG MEDICAID POLICY (REGULATORY/ADMINISTRATIVE) PRIORITY ISSUES
February 7, 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.