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SUBMITTED VIA: www.regulations.gov

June 1, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTENTION: CMS-1744-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS Medicare and Medicaid Programs: Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC)

Dear Administrator Verma:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), I write to provide comments on the Centers for Medicare & Medicaid Services (CMS) interim final rule, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (PHE)". Established in 1972, the NPAIHB is tribal organization formed under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, advocating on behalf of the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on specific health care issues.[1]

GENERAL COMMENT

NPAIHB is appreciative and supportive for many of the regulatory changes made in response to the COVID-19 pandemic. CMS' expansion of telehealth services during the PHE have benefited American Indian and Alaska Native (AI/AN) Medicare and Medicaid beneficiaries. Telehealth expansion recognizes the everyday barriers to care for AI/AN, and provides sustainable solutions to improve health care access and improve health outcomes for AI/ANs. There has been a reduction in no-shows and cancellations for routine visits and follow-up care. Health care delivery through telecommunications has provided greater protection and safety for our most vulnerable patients. Therefore, CMS must work with the Indian health system to authorize continued use of telehealth capabilities in delivery of health care services during and after the PHE.

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

SPECIFIC COMMENTS

NPAIHB provides the following recommendations on CMS' changes to Medicare payment rules for practitioners to furnish services using remote communications technology:

Reimbursement Rates for Indian Health Care Providers

CMS explains in the interim final rule that "it would be appropriate to assume that the relative resource costs of services furnished through telehealth should be reflected in the payment to the furnishing physician or practitioner as if they furnished the services in person, and to assign the payment rate that ordinarily would have been paid … were the services furnished in-person." (Fed. Reg. 85 at 19233). However, there are dramatically different rates for onsite physician services and distant site telehealth services. In-person services covered under Part B, including physician services, are paid at the OMB/IHS All Inclusive Rate (AIR), currently $479 per encounter for facilities in the lower-48 states.[2] The AIR is a flat daily cost-based average rate that is established annually by CMS and IHS and approved by OMB, based upon a review of yearly cost reports prepared by IHS's contractor.[3] The AIR reflects the cost of all services and supplies furnished by a tribal facility to a patient in a single day, and are not adjusted for the complexity of the patient's health care needs, the length of the visit, or the number or type of practitioners involved in the patient's care.

CMS currently pays only the assigned physician fee to the distant site tribal provider-based clinic, and nothing for the facility's associated costs - a $479 per visit differential for lower-48 Tribal facilities.[4] Tribal FQHCs are paid far less for those services during the PHE than they would be for the same service furnished in person. An in-person service would be paid at the $479 AIR, but a telehealth service will be at only $92.03.[5] In addition, not only is Medicare reimbursement less for Indian health providers, but IHS and tribal clinics have had to incur significant expenses to build the infrastructure for the extension of telehealth, which is not reflected in the current Medicare reimbursement rates for telehealth services.

These payment differences, and unanticipated costs, place a majority of the cost of telehealth services onto tribes and tribal health programs that are significantly underfunded. NPAIHB recommends that IHS and tribal clinics be paid at the same rate for telehealth services (virtual or telephonic) in alignment with services furnished during an in-person visit at the OMB/IHS All Inclusive Rate (AIR).

Payment for Medicare Telehealth Services under Section 1834(m) of the Social Security Act

[2] AIRs are published annually in the federal register. The 2020 rates were published at 85 Fed. Reg. 21864 (April 20, 2020), https://www.govinfo.gov/content/pkg/FR-2020-04-20/pdf/2020-08247.pdf. The higher rate for Alaska facilities reflects their much higher operational costs.

[3] CMS Medicare Claims Processing Manual Section (Publication 104), sec. 100.5.

[4] The originating site is paid the same $26.65 nominal originating site facility fee as for non-Tribal sites.

[5] CMS "MLN Matters" SE 20016, updated April 30, 2020, https://www.cms.gov/files/document/se20016.pdf.

Telehealth is a key component to ensuring AI/AN Medicaid and Medicare beneficiaries have access to health care when they do not have transportation to get to a provider or, as with COVID-19, someone is in a high-risk group for serious illness and should not visit a medical facility. IHS and tribal facilities have demonstrated that telehealth visits are safe and just as effective as an in-person visit to provide services to AI/AN Medicaid and Medicare beneficiaries during COVID-19.

NPAIHB is grateful for CMS' decision to waive limitations on the types of practitioners that can furnish Medicare telehealth services (Fed. Reg 85 at 19239). Prior to the change, only doctors, nurse practitioners, physician assistants, and certain others could deliver telehealth services. Due to the pandemic, CMS has authorized other practitioners to provide telehealth services, including physical therapists, occupational therapists, and speech language pathologists.

Telehealth Modalities Recommendations

NPAIHB is grateful to CMS for the expansion in modalities which telehealth can be delivered. We concur with CMS expanding the definition of "telehealth services" at 42 CFR 410.78(a)(3)(i) to include communication via smart phones and similar devices using platforms like FaceTime or Skype.

NPAIHB strongly supports the CMS decision to cover a range of "telephone assessment and management services," as well as the extended coverage for virtual check-ins and e-visits that do not ordinarily involve a face-to-face visit and thus do not qualify as telehealth services (Fed. Reg. 85 at 19265). As highlighted by CMS, these services have become an important part of overall physician care of Medicaid beneficiaries. These services are especially important during the current PHE and in the underserved areas served by the IHS and tribal health facilities.

Some of our AI/AN Medicare beneficiaries do not have access to interactive audio-visual technology that is required for Medicare telehealth services, or beneficiaries choose not to use it even if offered by their practitioner. This is particularly important for Medicare beneficiaries who lack access to broadband technologies in tribal communities and do not have equal access to care.

Direct Supervision by Interactive Telecommunications Technology Recommendations

NPAIHB strongly supports the amendments to allow direct physician supervision of non-physician providers to be furnished via interactive telecommunications technology during the pandemic (Fed. Reg. 85 at 19245). Remote supervision of non-physician clinical staff is crucial within the Indian health system because of our reliance on non-physician providers to furnish services due to the health care workforce shortage in our communities. The ability for non-physician providers to provide care under supervision of a remote physician expands the capacity of Indian health providers. We urge CMS to permanently adopt the supervision change after the PHE to address health care provider shortages in the Indian health system.

Recommendations on § 410.67 Requirements for Opioid Treatment Programs (OTP)

NPAIHB is supportive of the expansion of the use of two-way telephonic devices in providing opioid treatment services that are furnished via audio-only telephone calls "where audio/video technology is not available to the beneficiary" (85 Fed. Reg. at 19258). The opioid epidemic has devastated our communities and this is a much needed expansion to increase access to treatment and ensure continuity of treatment during the PHE.

CONCLUSION

NPAIHB requests that CMS honor trust and treaty obligations by taking into account the unique telehealth needs of Indian health providers and AI/AN Medicare and Medicaid beneficiaries. Thank you for consideration of our comments and recommendations. If you have any questions, please contact Sarah Sullivan, Health Policy Analyst at (503) 228-4185 or by email to ssullivan@npaihb.org.

Sincerely,

Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Nation Indian Business Council

cc: Kitty Marx, Director, Division of Tribal Affairs/IEAG/CMCS