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 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Center 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 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

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 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments" (CMS-1807-P). We appreciate CMS for working with TTAG to address our Tribal Priorities.[1] Namely, the proposed rule aligns with the TTAG Medicare Priority #4: Increase Flexibility in Medicare Definition of Telemedicine Services.

As a backdrop to our comments and recommendations, it is important to pay special attention to the historical inequities in our country's healthcare delivery system. While the federal agencies, including CMS, have worked tirelessly to implement the Biden Administration's objective set out in Executive Order 13985 of January 20, 2021, *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, disparities in healthcare access persist, particularly for American Indian and Alaska Native (AI/AN) beneficiaries. And on February 16, 2023, President Biden reaffirmed the administration's commitment to *Strengthen Racial Equity and Support for Underserved Communities Across the Federal Government* through Exec. Order 14091. Unfortunately, due to the historic drivers of health disparities, including U.S. termination and assimilation policies, many AI/AN communities remain underserved when it

[1] Email from AC Locklear, c/o the Centers for Medicare and Medicaid Services (CMS) TTAG Chair W. Ron Allen, to CMS Administrator Chiquita Brooks-LaSure, CMS TTAG Letter Regarding Tribal Priorities (March 3, 2023) (copied on email correspondence: Meena Seshamani, Director, Center for Medicare; Dan Tsai, Deputy Administrator and Director, Center for Medicaid and CHIP Services; and Kitty Marx, Director, CMS Division of Tribal Affairs).

comes to access to in-person healthcare services. Many AI/AN people face unique challenges and harsh living conditions resulting from removal policies and inadequate infrastructure. 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 impacts of U.S. policies as the root cause of the significant health disparities that affect the AI/AN population.

The COVID-19 Public Health Emergency (PHE) transformed the way healthcare services are delivered everywhere, particularly for Indian Health Service (IHS), Tribal, and Urban Indian (collectively I/T/U) healthcare delivery systems. Telehealth service expansion under the PHE underscores the potential to provide access to otherwise hard-to-reach patients for critical medical and behavioral health services, improving access for rural and underserved areas. Telehealth is a critical vehicle for achieving health equity for patients in communities that have long struggled to access timely healthcare services because the nearest facility is hours away and for whom travel may be prohibitively difficult. The temporary waiver of telehealth restrictions has demonstrated telemedicine's general safety and effectiveness 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. Making the existing temporary telehealth waivers permanent policy changes would ensure that the telehealth system remains a viable option for delivering essential medical, mental, and behavioral health services in Indian Country and help close the gap in access to care.

While we understand there are statutory limitations, the Medicare telehealth flexibilities made available during the PHE should be made permanent to the maximum extent possible, and we continue to advocate that more services should be allowed to be furnished via telehealth. Much of Indian Country is rural and lacks access to more advanced methods of audio and video real-time communication, and many AI/AN beneficiaries lack access to smartphones and other audio-video capable devices, as well as reliable broadband service.[2] 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, and not just for behavioral and mental health services.

Audio-Only Communication Technology. In response to the PHE, CMS allowed the use of audio-only communication technology to furnish audio-only telephone evaluation and management services, behavioral health counseling, and educational services. TTAG supports CMS-1807-P for the new proposed definition of "interactive telecommunication system," which would allow the use of two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of or does not consent to, the use of video technology. This proposed rule

[2] *See* Report on Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018, Federal Communications Commission, May 2019, https://docs.fcc.gov/public/attachments/DOC-357269A1.pdf

will increase access to much needed care throughout Indian Country, where broadband access is limited, and will continue to demonstrate the safety and effectiveness of telemedicine.

Opioid Treatment Programs. CMS is proposing to make permanent the current flexibility for furnishing periodic assessments via audio-only telecommunications beginning January 1, 2025, so long as all other applicable requirements are met. TTAG encourages CMS to work with its other federal partners with telemedicine regulatory authority to align and clarify opioid and substance use disorder treatment policies, for maximum flexibility to ensure patients can access and remain in treatment. Further, given the significance of the Opioid Epidemic in Indian Country, we encourage CMS to remove the requirement that providers of mental health or Opioid Treatment Program (OTP) services have audio-visual capability. Audiovisual and audio-only services are critical for achieving health equity for patients in communities that have long struggled to access behavioral health treatment, including Tribal Nations.

Direct Supervision. During the PHE, CMS amended the definition of "direct supervision" to permit a supervising physician/practitioner to be considered "immediately available" through virtual presence using two-way, real-time audio/visual technology for certain services. CMS originally extended this definition through December 31, 3024; in the Proposed Rule, this definition would be extended through December 31, 2025. We thank CMS for recognizing the importance of maintaining this flexibility to increase patient access to care. CMS also proposes to permanently define "direct supervision" that allows "immediate availability" of the supervising physician/practitioner using audio/video real-time communications technology for a subset of incident-to services. The ability of the billing practitioner to supervise services remotely is essential for Tribal health programs that serve rural and remote patients in locations where a practitioner is physically unavailable, and provider shortages are dire. We encourage CMS to include audio-only supervision and make these flexibilities permanent to expand the availability of practitioners for patients in the face of extreme provider shortages.

Frequency Limitations. We offer our support for CMS's proposal to continue the suspension of telehealth frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations for CY 25.

Distant/Originating Site Requirements. CMS noted the expiration of certain Medicare telehealth flexibilities related to the COVID-19 PHE, including the removing statutory geographic and location limitations of most Medicare telehealth services. However, CMS asserts that a beneficiary's home continues to be a permissible originating site for certain types of services, including those furnished for the diagnosis, evaluation, or treatment of a mental health disorder, including a Substance Use Disorder (SUD), and for monthly clinical assessments related to End-Stage Renal Disease (ESRD) described in Section 1881(b)(3)(B). Permanently allowing patients to receive telehealth care from home recognizes the geographic limitations that many AI/AN beneficiaries face when seeking services, and TTAG supports CMS's continuation here.

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) Telehealth. We thank CMS for collaborating with TTAG to ensure access to essential services provided by FQHCs and RHCs; however, the current flexibility allowing FQHCs and RHCs to receive payment for and serve as distant site providers for non-behavioral/mental telehealth services is set to expire

on December 31, 2024. We are in support of CMS's proposal to continue Medicare payment to FQHCs and RHCs for non-behavioral/mental telehealth services. We urge CMS to make this payment policy permanent to ensure that essential services provided via telehealth are not disrupted and to further support healthcare delivery in our rural communities. We also request that CMS permanently remove the requirement for in-person visits within six (6) months of an initial behavioral health/mental telehealth services and annually thereafter. We believe that CMS arbitrarily applied these in-person visit requirements on FQHCs and RHCs without any clinical evidence showing that virtual care is insufficient to require in-person visits.

CMS must implement new telehealth policies with the maximum flexibility possible to address persistent health disparities and make them permanent. We also request that CMS work with Congress to remove any statutory barriers to telehealth use for any Medicare service covered for face-to-face delivery, as appropriate. We recommend that CMS consider the unique needs of the Indian health system and the population it serves, as well as its unique obligations to Indian Tribes when finalizing this rule. We appreciate your consideration of the above comments and recommendations and look forward to engaging with your agency further.

Sincerely,

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