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

December 11, 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 to: Chiquita.Brooks-LaSure@cms.hhs.gov

Re: Follow Up from the November 2024 Centers for Medicare and Medicaid Services Tribal Technical Advisory Group Face-to-Face Meeting

Dear Administrator Brooks-LaSure:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), I write to express our deep gratitude and appreciation of your leadership during this Administration that has resulted in numerous successes. Thank you for your commitment to working with TTAG and bringing our priorities into fruition. Your public service to Indian Country has been transformative and will usher in improved health outcomes for generations to come. We would like to extend our deep appreciation to this Administration as we continue to address barriers we experience to access and provide quality healthcare for our Native citizens.

I. Thank You on the 1115 Demonstration Waivers for Traditional Health Care Practices

We would like to extend our deepest gratitude to CMS for their historic approvals' of 1115 demonstration waivers in Arizona, New Mexico, California, and Oregon allowing for the coverage of traditional health care practices. We are pleased that CMS took our requests into consideration allowing for coverage at Indian Health Service (IHS), Tribal, and urban Indian organizations (UIOs); covering services on-site and off-site to optimize care for patients; allowing for reimbursement of services at the IHS All-Inclusive Rate, and; allowing each facility to determine the qualifications, training, and expertise for traditional healing practitioners. This long-time request will provide valuable resources to support our traditional practices to optimize the health outcomes of American Indian and Alaska Native (AI/AN) patients.

These historic approvals are a landmark step forward in providing quality, culturally-appropriate health care for Tribes and their citizens, but the implementation will need to be monitored to ensure States develop meaningful collaboration with the Indian

healthcare system. We urge CMS to evaluate Tribal and UIO engagement and input on evaluation criteria when reviewing States' evaluation plans. It will also be critical for States to meaningfully incorporate input from Tribes and UIOs on this new endeavor to ensure the intent and purpose of this waiver is upheld across all States to maximize the impact for Native beneficiaries.

The news of the approvals for 1115 demonstration waivers offering reimbursement for traditional healing practices has spread throughout Indian Country, and many Tribes are interested in beginning their own applications. Implementation funding is particularly important for the feasibility of standing up new traditional healing programs within the Indian health system. We would like to request CMS provide additional information on the availability of this implementation funding and how CMS makes decisions about awarding this funding.

II. Gratitude for the OPPS Final Rule

We are immensely grateful for the inclusion of the regulatory fix for the Four Walls issue in the Medicare Outpatient Prospective Payment and Ambulatory Surgical Center Payment System Final Rule. For years, we have been told that it was impossible to fix this issue, but this Administration found a solution. This improvement will allow clinics to provide services outside the four walls and still get reimbursed at the facility rate which will immensely improve accessibility to care. We raise our hands to the Division of Tribal Affairs and CMS for resolving this issue and reducing barriers to providing care to Native beneficiaries.

We would also like to extend our gratitude for the inclusion of the high-cost drugs provision in the OPPS rule. By reducing the burden on Tribes to pay so much out of pocket, the well-being of Native beneficiaries will be protected.

TTAG's leadership would like to continue working with CMS on our recommendations not included in the final rule such as it may not be possible to provide all of the requested data to fully implement this ruling. To support the Indian healthcare system, which has a nominal impact on the total Medicare expenditures, we request that CMS include a proposal in next year's proposed OPPS rule to allow Indian outpatient facilities that request it to be reimbursed at the Medicare Outpatient All-Inclusive Rate. These further recommendations can maximize the resources needed for facilities to deliver high-quality and culturally appropriate care.

III. Medicaid Redetermination

TTAG appreciates the extension of temporary unwinding, and related flexibilities, that will run until June 2025. TTAG also appreciates the guidance CMS issued to states in response to the issues Indian Country identified with state implementation of Medicaid Unwinding. Unfortunately, some states have not incorporated this guidance into their operations and procedural disenrollments remain a significant issue for AI/AN beneficiaries.

TTAG's leadership requests that CMS further educate and encourage states that have not pursued the 1902(e)(14)(A) waiver unwinding flexibilities outlined in the May 9, 2024, CMCS bulletin to take advantage. Many AI/AN people have been disenrolled and require immediate assistance. TTAG looks forward to sharing the resources available for Unwinding set to be uploaded to the landing page in December 2024. Finally, TTAG looks forward to continuing our work on redeterminations with CMS even as Medicaid unwinding comes to a close. The systemic issues in the redeterminations process are an opportunity for improvement in support of our Medicaid beneficiaries.

IV. Arizona Fraud

The exploitation of the American Indian Health Program (AIHP) in Arizona by bad actors has strained IHS, Tribes, and UIOs who have received no support or compensation for the Native patients they serve in the continued fallout from fraudulent billing made to the Arizona Health Care Cost Containment System (AHCCCS). The TTAG remains deeply concerned that the AHCCCS is moving forward with several changes to the operation of the AIHP which could result in significant barriers to care for AI/AN Medicaid beneficiaries and administrative burdens for Indian health care providers (IHCPs) that hinder their ability to provide care to eligible AI/AN beneficiaries in need.

CMS has stated this is a law enforcement issue, however, swift action is needed by CMS to meet the needs of AI/AN Medicaid beneficiaries who have been impacted by this fraud. CMS must exercise oversight over AHCCCS to prevent these changes from becoming permanent and creating long-lasting barriers to care for AI/AN Medicaid beneficiaries in Arizona. Tribal leaders understand that Medicaid is a shared state-federal program, but CMS has a unique responsibility to protect AI/AN Medicaid beneficiaries that it does not have for other beneficiaries in the program due to the United States' trust obligation for the health of AI/ANs. CMS should exercise its oversight authority in several ways including providing resources to the Tribal programs and UIOs who responded to the care of AI/AN patients impacted; ensure that any state correction does not negatively impact the delivery of care, and; oversight of state implementation of the Medicaid program to ensure that AHCCCS does not create disparities in access while upholding the integrity of the program. CMS must recognize its role in the government-to-government relationship and provide the oversight needed to ensure the Medicaid program is meeting Tribal programs' and AI/AN beneficiaries' needs.

We encourage CMS to work with the Operational Divisions within HHS to properly investigate the program's failures which led to fraudulent billing in Arizona by utilizing the investigative authority found in the HHS Office of Inspector General. It is OIG's mission to "provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs," including Medicaid, and to promote "the health and welfare of the people [HHS programs] serve." Given the extent of the truly horrible crimes perpetrated against our people and the millions of dollars wasted, this is unacceptable.

To ensure responsibilities to AI/AN beneficiaries are upheld, CMS must work with Tribes and UIOs through Tribal Consultation and Urban Confer to ensure that any proposed changes are only developed through partnership with IHCPs. CMS must provide regular communication with Tribes and TTAG as it addresses this issue to ensure that the current needs of Tribes and UIOs are addressed, and they are financially compensated for their care to Native Medicaid beneficiaries. Future best practices must be developed in coordination with the Indian healthcare system to prevent this wrongdoing in the future.

V. Thank You for the Expansion of Telehealth

Thank you for your leadership and working by our side to address the TTAG Medicare Priority to increase flexibility in the Medicare definition of telemedicine services in the Physician Fee Scheule Final Rule. Further, expanding the definition of "interactive telecommunication systems" is greatly appreciated. This rule will expand access to care for our Elders in especially rural areas across Indian Country that have extremely limited access to in-person care.

VI. Part D

Medicare Part D Addendum. We appreciate the minor edits made to the Part D Addendum, however, we are frustrated that further edits are being limited to the current RFI on the Paperwork Reduction Act. TTAG is interested in updates to the addendum, including going beyond the Part D plans so that it applies to other pharmacy plans, as proposed by Tribal leaders in September 2024. Tribal Leaders would like to discuss this issue outside of the RFI.

Tribal edits included provisions to prevent pharmacy plans and other issuers from refusing to properly pay, or discounting reimbursements based on a Tribe's access to discounted pharmaceuticals; repackaging pharmaceuticals purchased through federal sources of supply; refusing reimbursement based on mail order pharmacy or specialty pharmacy, or other reasons. Some examples of issues experienced include Pharmacy Benefit Managers refusing to pay for a medication that was refilled a day before it was supposed to and refusing reimbursement when I/T/U providers exercise their right to repackage pharmaceuticals. These issues are addressed in our recommendations and uphold Section 206 of the Indian Health Care Improvement Act which requires all issuers to pay I/T/U providers at the highest rate they pay other in-network providers.

TTAG has again submitted comments under the Paperwork Reduction Act and we look forward to continuing this conversation with decisionmakers at CMS. We hope this reoccurring issue is resolved in a timely manner to secure obligated resources for I/T/U providers.

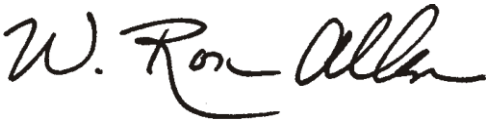
VII. Other Medicare Issues

Managed Care Retroactive Claims Review: Tribal clinics in Idaho are having multiple challenges submitting claims and getting paid by the Medicare Medicaid Coordinated Plan (MMCP) for Medicare and Medicaid "dual eligible" beneficiaries. Historically, the MMCP issuers refused to correctly pay the All-Inclusive Rate (AIR) on the cross-over claim to IHS and Tribally operated clinics as the managed care plan did not retroactively process claims submitted for dates of service prior to the publication of the AIR in the federal register. For example, if the AIR was published on April 1, all claims from January - March were paid at the previous year's IHS AIR. Tribes have not been made whole for previous reduced AIR payments. These issues have also been compounded because Tribal members are being auto-enrolled into the MMCP managed care plans in some counties. And these MMPC issuers are requiring Tribal clinics to jump through hoops to get paid by the plans. Tribes in Idaho would like to have a retroactive claims review, going back five years, of all claims in which the AIR was paid incorrectly, and Tribes would like to be made "financially whole." Tribes in Idaho would also like CMS to provide technical support to the State of Idaho and help state officials understand their obligations to the Tribes when contracting with managed care organizations in the state.

Reimbursement for Crossover Claims: Tribes are losing revenue due to the inability to submit crossover claims to Medicaid for payment. For example, a Tribal citizen may receive services from a provider-type that is not recognized by Medicaid and there is no process to submit a claim to Medicare for a denial. Without an initial denial letter, the Tribe is unable to submit a crossover claim to Medicaid for reimbursement of the service. We urge CMS to allow Tribes to submit retroactive claims going back at least five years and TTAG reiterates our request to expand provider types reimbursable under Medicare.

Our TTAG leadership is thankful for our collaboration on decades long issues that will have a lasting impact on the Indian healthcare system. Our accomplishments are noteworthy and would not be possible without your dedication and commitment to improve the lives of Indian Country.

Sincerely,



W. Ron Allen, CMS TTAG Chair
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