**TSGAC ACA/IHCIA Project Priority Issues**

February 17, 2021

| TOPIC | | ISSUE DESCRIPTION | DATES, UPDATES, & ACTIONS | NOTES |
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| COVID-19 Testing Reimbursement  *CMS* | ***Issue:*** Medicare is not reimbursing tribal hospitals for COVID-19 testing at the OMB encounter rate, and instead paying only a nominal collection fee.  ***Issue:*** Price Transparency Relation (CMS-9912-IFC) requires all providers to publish the cash price of COVID-19 diagnostic tests. There is currently no exception.  ***TTAG Medicare Priority:*** Increase Reimbursement to Tribal Hospitals for COVID-19 Testing | | * ***Tribal Request:***   CMS should clarify that IHS/Tribal should be eligible for reimbursement at the encounter rate, since the facility continues to bear the same costs for collection, processing, analyzing, handling and follow-up on the results.  [**CMS Coverage and Reimbursement of COVID-19 Vaccine Toolkit**](https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf)  [**CMS COVID-19 Medicare FFS Billing**](https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf) **(12/9/20)**   * **1/4/2021:** TSGAC **s**ubmitted comments to CMS on the Price Transparency Regulation (CMS-9912-IFC). | * The first issue has been resolved. An IHS/Tribal hospital outpatient visit for COVID testing will qualify as a billable encounter even if the person doesn’t have a f2f encounter with a provider. Will be effective for diagnostic testing on or after March 1, 2020 and will be effective through the COVID Public Health Emergency. |
| COVID-19 Vaccine  Distribution, Testing, and Medical Supplies  *HHS, IHS, CDC* | ***Issues:***   1. Need to scale up vaccination distribution, COVID-19 testing, and medical supplies. 2. It must be a higher priority for Tribal members to receive the vaccine quickly. 3. Data lag between what Tribes are recording and the CDC Tracker. 4. Tribal autonomy to make vaccine distribution decisions. 5. Concern from TSGAC that Tribes are not categorized as Public Health Entities similar to local public health districts. | | [**IHS COVID-19 Vaccine Plan**](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/Enclosure_DTLL_DUIOLL_11182020.pdf)  [**11/18/2020 IHS Vaccine Distribution Final Plan DTLL**](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_DUIOLL_11182020.pdf)  [**CDC Vaccination Playbook**](https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf)   * **FOLLOW-UP**: TSGAC circulated a summary of the IHS Vaccine Distribution plan. IHS is working on a reimbursement matrix. | * Tribal Epi Centers need to be informed. * Need for resources for remote areas to meet the special handling requirements. |
| COVID-19 Funding  *IHS, HHS* | ***Issues***:   1. Concern with the formula used to generate the $500M IHS/Tribal set aside in the Provider Relief Fund.  HHS originally indicated it used a $3,943 cost per individual as the basis for the funding formula. 2. Funding needed for vaccine storage, medical supplies/PPE, and supplemental medical personnel. 3. Funding needed for COVID-19 testing. 4. Funding for third-party revenue loss. 5. Funding needed for mental and behavioral health. 6. Funding for broadband infrastructure for adequate telehealth. 7. Funding needed for culturally relevant outreach and education to build vaccine acceptance. | | [**4/23/2020 TSGAC COVID-Funding Webinar**](https://www.tribalselfgov.org/health-reform/webinars/july-16-2020-tsgac-aca-webinar-covid-19-tribal-health-care-funding/)  [**HHS PRF Reporting Guidance**](https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/reporting-auditing/index.html)  [**COVID-19 Relief Funding Tribal Joint Letter to Congress**](https://www.nihb.org/covid-19/wp-content/uploads/2020/09/FINAL_-September-2020-COVID-health-letter.pdf)  **FOLLOW-UP**: Following what happens in the next legislative package.   * + Future funding allocations for IHCPs should be based on actual cost to provide care, not the underfunded IHS.   + Potential follow-up webinar after next legislative package is released. | * **1/15/2021**: HHS/IHS has new reporting requirements and portal is open for registration purposes only. HHS will notify providers when they need to report. |
| COVID-19  Inter-Agency Agreements (IAA)  *IHS, VA* | ***Issues:***   1. IHS has entered into an IAA with the Strategic National Stockpile to access hard-to-find PPE and $10M has been allocated for critical supplies. 2. IHS has entered into an IAA with VA for surge bed capacity for IHS facilities. 3. Funding allocated to Tribes through SAMHSA or CDC are required to be made through grants. Need a statute to override the grants-mechanism to transfer to IHS. | | **FOLLOW-UP:** Tribes to talk with legislators about the need for legislation that would allow COVID-19 relief funds allocated to Tribes through SAMHSA and CDC to be transferred to IHS and able to be provided through Funding Agreements. | * Need for IAA between IHS and SAMHSA as well as IHS and CDC to use funding through ISDEAA. * Need to put together a team to develop a plan for how this could work. |
| Telehealth Expansion  *CMS* | ***Issue:*** Need for expansion of reimbursement for telehealth services through [CMS Medicare & Medicaid](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.). More of an issue with Medicare limiting reimbursement. | | [**12/20/2020 CMS Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients.**](https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment)  [**Executive Order on Rural Health and Telehealth**](https://www.whitehouse.gov/presidential-actions/executive-order-improving-rural-health-telehealth-access/)  **CMS Matrix of Telehealth Services**  [**Medicare Telemedicine Health Care Provider Fact Sheet**](https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet)  [**Medicaid & CHIP Telehealth Toolkit**](https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf)  [**Long Term Care Nursing Homes Telehealth Toolkit**](https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf)  [**9/23 TSGAC Telehealth Webinar**](https://www.tribalselfgov.org/health-reform/webinars/aca-webinar-recent-updates-and-innovations-in-telehealth/) | * TSGAC request to establish a Joint Tribal/Federal workgroup to support telehealth expansion. * IHS is in the process of finalizing a Project Management office to address overall support, modernization strategies to bring resources to stakeholders. * Tribes who participate in the Medicare QPP have had to request 5 hardship exemptions because RPMS does not meet the CMS requirements. Concern over penalties that these clinics will have to pay. |
| 340B Drug Discount Program  *HRSA* | ***Issue*:** A number of pharmaceutical manufacturers announced they will no longer allow access to 340B drugs through contract pharmacies. Other pharmaceutical manufacturers are attempting to require covered entities to submit to burdensome data sharing requests in order to receive 340B drugs.   * The 340B program allows covered entities, which include tribally operated outpatient clinics, to get discounted/repriced drugs. HRSA guidelines allow tribal clinics without pharmacies to get access to 340B drugs using contract pharmacies. * Some pharmaceutical companies are no longer providing access to 340B drugs through contract pharmacies. This is inconsistent with the 340B statute and HRSA guidelines that have been in place since 1996. * Some manufacturers have asked Tribal clinics to sign-up to a manufacturer portal. There is no requirement to submit this burdensome reporting. | | [**12/30/2020: HRSA Advisory Opinion 20-06 on Contract Pharmacies Under the 340B Program**](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/340B-AO-FINAL-12-30-2020_0.pdf)   * **HRSA clarified that drug manufacturers must provide 340B discounts when a contract pharmacy is acting as an agent of a covered entity, providing services on behalf of the covered entity.**   10/7/2020 HRSA Consultation | * Two lawsuits have been filed against HHS to require HRSA to enforce the law, and to promulgate alternative dispute resolution regulations required by the 340B statute. These regulations would give covered entities like Tribal clinics the right to dispute actions of manufacturers like these. * Senate Republicans have requested testimony on how to improve the 340B program * HRSA implemented the Alternative Dispute Resolution regulations. Tribes can file claims against manufacturers through this ADR process. |
| CHAP Nationalization  *IHS, HHS, CMS, SAMHSA, HRSA* | Initiation of tribal consultation on the use of $5M from FY 2020 appropriations (available until 9/30/21). Feedback requested:   * How funding can be used to support Tribes to begin operating CHAP; * Development of National and Area Certification Boards; * Training investment; and * Community education. | | [**DTLL: 9/21**](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_09212020.pdf)  [**CHAP Policy: 7/2**](https://www.ihs.gov/ihm/circulars/2020/community-health-aide-program/)   * 11/20/2020 TSGAC submitted comments on the $5 million for national CHAP expansion. * **FOLLOW-UP**: Need for resources for training, certification and reimbursement * Inclusion of ISDEAA and Self-Governance Tribes from the beginning. * Creation of CHAP Brief for Self-Gov Tribes. | * National CHAP creation- Indian Health Manual Circular 20-06 * IHCIA Sec.119: Authorizes the Secretary to establish a national CHAP. * Sec.10221(b) of ACA allows use of DHATs when authorized under state law. * Involve TSGAC before decisions are made. * TSGAC submitted comments. |
| Medicare Priority Issues  (non-COVID-19)  *CMS, IHS* | 1. Need for update to Chapter 19 of the Medicare Claims Processing Manual to correct billing disputes with Novitas, the CMS IHS/Tribal MAC. 2. Need for an IHS/Tribal Accommodation under the Hospital Acquired Condition (HAC) Rules for Tribal hospitals to not be identified as “lowest performing hospitals”, even though they are well performing hospitals. Exemption for IHS Hospitals from the Hospital Star Rating System 3. Increase flexibility in Medicare Definition of Telemedicine Services. 4. Medicare Part C – Payment by Medicare Advantage Plans at OMB rate. Medicare Advantage plans are not reimbursing Indian health care providers at the IHS OMB rates, and often refusing to reimburse at all. 5. Medicare Part D Reimbursement from PBMs are reducing payments and reimbursement is being based on tribes’ ability to access drugs at discount rates. 6. Medicare does not allow reimbursement to Tribes for direct sponsorship of Part B premiums, similar to the option States have. 7. IHS Outpatient encounter rate could be made available to all Indian outpatient programs that request it. A permanent fix is needed for grandfathered Tribal Providers/FQHCs. 8. Provide Relief from Medicare Part B penalties for AI/AN elders. MedicarePart B imposes penalties for individuals who delay enrollment once they are eligible. 9. Community education necessary to prevent predatory Medicare Advantage enrollment practices. 10. Ensure IHCPs that continue to use RPMS can obtain hardship exemptions. 11. Exempt I/T/U DME Suppliers from Competitive Bidding Process | | 1. ***Tribal Request:*** CMS should schedule a workgroup to work through TTAG suggested revisions to the claims processing manual. 2. ***Tribal Request:*** CMS change its Hospital Acquired Condition (HAC) regulation, or issue guidance to account for the formula error that is inaccurately reporting many IHS and tribal hospitals as low performing. 3. ***Tribal Request***: Medicare should allow telehealth to be provided through audio-only telephonic and two-way radio communication methods when necessary. 4. ***Tribal Request:***  As a cost-based rate, the IHS OMB rate at the very least should be considered "reasonable costs" for purposes of Section 206 of IHCIA. 5. ***Tribal Request:*** These practices must stop because facilities are being negatively affected and PBMs are inaccurately reporting low performance for medication adherence. 6. ***Tribal Request:*** TTAG supports eliminating Part B premiums entirely for AI/AN beneficiaries. However, if premiums are retained, Indian health programs should be given the same option as States, to pay them directly on behalf of their beneficiaries. 7. ***Tribal Request:***  TTAG has been urging Medicare to authorize all Indian outpatient programs that request it to bill at the IHS outpatient encounter rate. CMS’s tribal provider based rules at 42 CFR § 413.65(m) and 42 C.F.R. § 405.2462 to allow all Indian outpatient programs to bill at the IHS Outpatient encounter rate. 8. ***Tribal Request:*** TTAG believes that AI/AN individuals should be exempt from all Medicare Part B premiums, if Part B premiums are retained, at a minimum IHS coverage should be deemed creditable coverage so that AI/AN Part B enrollees are not subject to late-enrollment penalties 9. ***Tribal Request:***  Funding is needed for enrollment assistance to provide education for AI/ANs to help them understand how their services at I/T facilities would be impacted if they enroll into a Medicare Advantage plan. 10. ***Tribal Request:***  Assistance from CMS in ensuring that IHCPs are not subject to penalties while the IHS considers whether to update RPMS or not while moving to a different system. 11. ***Tribal Request:*** Exemption from the competitive bidding process so as to allow Indian health care providers to access and bill for DME. | **1.** CMS has had a call with the workgroup to go through these issues.  **2**. TTAG 11/18/20:  The new HAC Care Compare site launched on 12/1/2020 and doesn’t reflect the same negative perception, which should help with the PR issues. CMS will be holding a webinar in the future for Tribal hospitals and how to calculate the HAC score.   1. 1/14/2021 CMS submitted letter to TTAG in response to request to amend regulations to make all Indian outpatient facilities eligible for reimbursement at the IHS Medicare outpatient encounter rate without cost reporting requirement.  * According to CMS, Providers participating in the Medicare program are required to submit annual information to achieve settlement of costs for healthcare services to Medicare beneficiaries. * To pay grandfathered FQHCs the Medicare outpatient rate, CMS would need to undergo notice and comment rulemaking. |
| Medicaid Priority Issues  *CMS, IHS* | 1. Extension of grace period for four walls limitation. 2. CMS should encourage States to increase Medicaid Telehealth reimbursement for IHCPs. 3. Issue Medicaid SHO Letter to Managed Care Organizations. 4. Shield IHCPs from State benefit cuts to Medicaid or enrollment limitations. | | 1. ***Tribal Request:*** Tribal request for an extension to January 2022 has been granted. During the grace period, we also urge CMS to reconsider the four-walls limitation. 2. ***Tribal Request:***  CMS should issue guidance to States confirming that they can authorize Medicaid reimbursement for telehealth services at the IHS OMB rates. 3. ***Tribal Request:***  CMS should issue a SHO letter informing States that they will be required as a condition of approving any managed care SPA or waiver to include compliance with the requirements at 42 C.F.R. § 438.14 as a condition of payment in their contracts with MCOs. CMS should also require that MCOs deem all IHCPs to be in-network regardless of whether they enter into a network provider agreement or not. 4. ***Tribal Request:***  CMS must be willing to entertain similar waivers that exempt cuts for services received through IHS and tribal providers that are eligible for 100% FMAP reimbursement. | * CMS is rethinking the Managed Care Oversight infrastructure. CMS is holding a roundtable with MCOs and Tribal representatives.      * CMS has developed a protocol where NACs for your area can be a POC and once they receive a complaint from an IHCP, the NAC can work with CMS to determine   if there is a violation of managed care rules. It will track the issues, have a point of contact and this will expedite resolutions. |
| Medicaid Expansion  *CMS* | ***Issue***: To date, 39 states (including DC) have adopted Medicaid expansion and 12 states have not adopted the expansion.   * States that have not adopted Medicaid expansion: WY, SD, KS, TX, WI (partial Medicaid expansion), TN, MS, AL, GA, FL, SC, NC. | | [**Kaiser Family Foundation Status of State Medicaid Expansion Map**](https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/) |  |
| 1115 Waivers  *CMS* | ***Issues:***   * Arizona waiver pending that would exempt AI/AN beneficiaries from $1000 cap for dental services, would authorize reimbursement for traditional healing and would extend uncompensated care waivers | | [**CMS Waivers**](https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html) | * CMS expected to take action to rescind approval of all work requirement related waivers |
| Tribal Sponsorship  *CMS* | ***Issue***: How many Tribes are participating in Tribal sponsorship? | | [**TSGAC Tribal Sponsorship Key Tasks**](https://www.tribalselfgov.org/health-reform/health-q-a/tribal-sponsorship-fast-track-key-tasks/)   * TSGAC provided presentation to Native American ContactsOctober 19. |  |
| Marketplace  *CMS* | ***Issues:***   1. Marketplace enrollment is increasing, but compared nationwide it is not a significant increase. 2. Increase AI/AN (FFM) enrollment with zero and limited cost-sharing protections. 3. Increase enrollment in bronze metal level Marketplace plan for AI/AN enrollees to receive the greatest value. 4. *Enrollment Issue somewhat-resolved*: a member of a federally recognized tribe won’t be able to use the special cost-sharing savings if they enroll in the same Marketplace plan with a non-tribal member. Tribal members and non-tribal members should enroll in separate plans to take advantage of all potential savings. | | * CCIIO included all of TTAG’s suggestions into the 2021 plan year letter to issuers. Directs issuers to the zero and limited cost sharing language in the SBC.   [**11/25/2020 CMS Proposed Rule Seeks to Reduce Exchange Fees to Lower Premiums for Plans using the Federal Enrollment Platform**](https://www.cms.gov/newsroom/press-releases/cms-proposed-rule-seeks-reduce-exchange-fees-again-lower-premiums-plans-using-federal-enrollment)  [**TSGAC Marketplace Matrix**](https://www.tribalselfgov.org/wp-content/uploads/2020/02/rev-Matrix-CCIIO-Issuer-Letters-Select-Marketplace-Issues-2014-2021-2020-02-05b.pdf)  **FOLLOW-UP:** Analyze 2020 Marketplace data and send letter to CMS on policy and guidance requests related to trends in Marketplace enrollment.  Update TSGAC briefing paper on key findings. | * TTAG Policy Subcommittee recommended change to Q&A for households consisting of AI/ANs and non-AI/AN family members. CCIIO made the requested changes. * 11/10/2020: Texas v. U.S hearing before the Supreme Court |
| VA Reimbursement/ VA-THP Contracts  *IHS,VA* | ***Issues***:   1. VA and IHS amended the national Reimbursement Agreement:  * Includes telehealth as “direct care services”; * Extension of agreement until June 30, 2024; * Clarifies language in quality section for certification and accreditation requirements; and * Adds new section for reimbursement for care provided by IHS through PRC program during COVID-19 emergency (need to make this permanent).  1. Reimbursement from VA for PRC Services 2. Elimination of co-pays for AI/AN Veterans 3. Transparency and enhancement of Tribal Health Program reimbursement agreements. 4. Development and implementation of the VA Tribal Advisory Committee. | | [**IHS & VA draft final MOU**](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/Enclosure_DTLL_12022020.pdf)  [**VA DTLL (Dec. 2)**](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_12022020.pdf)   * 12/24/2020: [**3 Native Veteran Health laws were passed within H.R. 7105**](https://www.congress.gov/bill/116th-congress/house-bill/7105/text?q=%7B%22search%22%3A%5B%22johnny+isakson+veteran+bill%22%5D%7D&r=1&s=1)**:** * Native American Veterans PACT Act eliminates copayments for AI/AN Veterans accessing VA healthcare; * PRC for Native Veterans Act clarifies reimbursement from VA and DOD for healthcare services provided to AI/AN Veterans through an authorized referral; and * Veterans Affairs Tribal Advisory Committee Act of 2019.   **FOLLOW-UP:** Submit comments on the IHS and VA Draft Revised MOU, which are due **3/2/2021**. | * VA reports that 116 Tribal Health Programs have individual reimbursement agreements with the VA/VHA. The agreements vary immensely. |