**TSGAC ACA/IHCIA Project Priority Issues**

Updated: 2/2/2022

| TOPIC | | ISSUE DESCRIPTION | TRIBAL REQUESTS & RECOMMENDED TSGAC ACTION | NOTES |
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| CMS COVID-19 Health Care Staff Vaccination Interim Final Rule | On November 5, 2021, CMS and the Occupational Safety and Health Administration (OHSA) separately released two new vaccination requirements.  On January 13, 2022, the Supreme Court struck down the OSHA vaccine mandate but let the CMS vaccine mandate stand.  On January 14, 2022, CMS issued new guidance and new implementation dates for the 25 States in which the CMS vaccine mandate had been blocked pending Supreme Court review. This guidance supplements the original guidance issued by CMS on December 28 that is still in effect for the 24 States where the mandate had not been blocked. On January 20, CMS issue new implementation dates for covered facilities in Texas, the remaining state.  The December 28 guidance applies to the following states: California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, Washington, and Wisconsin. The compliance deadlines for the December 28 Guidance are January 27, 2022 (phase 1), and February 28, 2022 (phase 2).  The January 14, 2022 guidance applies to the following states: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Utah, West Virginia, and Wyoming. The compliance deadlines for providers in these states are February 14, 2022 (Phase 1) and March 15 (Phase 2).  The January 20, 2022 guidance applies to Texas. The compliance deadline for covered providers in Texas is February 19, 2022 (Phase 1) and March 21, 2022 (Phase 2).  ***Issue:*** CMS has confirmed that only Medicare certified facilities included in the interim final rule which appear in the following database, [www.qcor.cms.gov](http://www.qcor.cms.gov) are covered (having an independent lab listed does not count). CMS has produced a list of IHS and tribal facilities in the database that are covered by the rule. Clinics that enroll only in Medicare Part B and are not independently certified by Medicare as a Medicare FQHC or otherwise are physicians offices and not covered by the mandate. CMS will be holding a tribal consultation call on the rule on February 10, 2022.  ***Issue:***  Tribes are concerned that CMS failed to consult with tribes before the rule was published and have asked CMS not to implement it in tribal facilities until CMS has engaged in tribal consultation on the rule.  ***Issue:*** Tribes are concerned that implementing a vaccine mandate without other testing alternatives could lead to increased staffing shortages. | | ***Tribal Recommendations:***   1. CMS should not implement the rule in Indian country until it consults with Tribes on the rule. 2. CMS should amend its FAQs on IHS/Tribal health facilities to clarify that if a facility is not listed on the qcor.cms.gov database, then the facility is not covered by the mandate. 3. CMS should allow facilities to use negative testing as an alternative for employees who do not wish to be vaccinated.   ***TSGAC Actions:***   1. Tribes, as sovereign nations, should be permitted to address vaccine requirements in whatever way they see fit. 2. Continue advocacy efforts to get CMS to clarify the scope of the rule and consult with tribal governments before implementing it in Indian country | * **FAQ for the Rule:** [**https://www.cms.gov/files/document/cms-omnibus-covid-19-health-care-staff-vaccination-requirements-2021.pdf**](https://www.cms.gov/files/document/cms-omnibus-covid-19-health-care-staff-vaccination-requirements-2021.pdf) * **The December 28 guidance can be found** [**HERE.**](https://r20.rs6.net/tn.jsp?f=00120cdShI-n3FKaJZmcOQwyBW6ZkjVQJocmXbVNidREeZYPHqbILtlyIFnTUfLwf5HKn4j3trfdr_qPLJR3vUQxHl6BWBXKgZ1I1WXeTHKcnVxeQpCwTqHL-eaLcOj6-BuEJNl6v8iBHbYQ5Ehk8GUSkbr6gGoSEJp9p9wL7wEmDwCp5tWlbJcb0RAaMBQlOTwik4D9LtqdVf0HoGWu1BipgQikzR6BXNbdBnYbnKSGS5qcLanMCJzUBs95UMzwYz6rhQUHPFt1GHN_gOC4BEwOiCPYEVHKaI6AdbkNJoiNdELdk61w8fyC_YyJk1pJafXUS2VVoujr2vlEJPkzPt0VN2jsERBY91EY-6IEt7W_qauzZsVnxLHZEec8f6spBT4Y9AlK5y1oZpoCO-RQtqG8Q==&c=5gzPHbO81WdBajdUb7_bcuXFelF6id_t4wSU5HVobNV4PnZDx-mZNQ==&ch=cwwvvMPIp04uadwdND-SZJg5llRrxbqDvAgPvo1WUUp4aa2y2pPIyA==) * **The January 14 guidance can be found** [**HERE**](https://www.cms.gov/files/document/qso-22-09-all-injunction-lifted.pdf)**.** * **The January 20 guidance can be found** [**HERE**](https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/guidance-interim-final-rule-medicare-and-medicaid-programs-omnibus-covid-19-health-care-staff-2)**.** |
| Medicare & Medicaid Telehealth Flexibilities  *CMS* | COVID-19 has demonstrated that telehealth can increase access to primary, specialty and behavioral health services particularly in rural areas.  CMS has confirmed in its State Medicaid/CHIP Telehealth toolkit that there is significant flexibility for States to allow telehealth services to be reimbursed in the same manner as in person services in the Medicaid program.  The Medicare program has significant statutory restrictions on the provision of telehealth which CMS has been able to lift during the public health emergency but will return once it is over.  In the 2020 CMS Physician Fee Schedule Final Rule CMS added 60 additional services for Medicare telehealth reimbursement.  On November 19, 2021, CMS published a final rule that retains Medicare telehealth service added during the pandemic through the end of CY 2023; creates a longer virtual check-in service; authorizes Rural Emergency Hospitals to be telehealth originating sites; requires in-person visits within 6 months of initiating service and every 12 months for mental health telehealth patients; authorizes the use of audio-only technology under certain circumstances for mental health visits where a home is the originating site; and allows payment for mental health telehealth visits at Rural Health Clinics and Federally Qualified Health Centers.  ***Issue:*** Current rates for and restrictions related to providing telehealth are not sustainable, thus Tribes are having to subsidize costs of providing services and patients have unnecessarily limited access to care. | | ***Tribal Recommendations:***   1. Congress removing geographic and site of service restrictions on Medicare telehealth services; 2. Congress expanding the types of providers that may bill for Medicare telehealth services; 3. Congress allowing facilities to collect a fee when they are coordinating telehealth visits for patients in their homes; 4. CMS permitting further expansion of audio-only telecommunications systems to be used to deliver Medicare telehealth services, including audio-only telephones and two-way radios; 5. CMS ensuring that Medicare reimburses Indian health care providers for telehealth services at the OMB rate; 6. CMS permanently expanding, in consultation with Tribes, the types of services eligible for Medicare telehealth reimbursement; 7. CMS continuing to expand, in consultation with Tribes, the availability and sustainability of virtual check-ins and e-visits, including allowing them for new patients; 8. CMS permanently authorizing direct supervision requirements for services incident to a physician's services to be fulfilled using real-time interactive audio and video technology; and 9. CMS issue guidance to States confirming that they can authorize Medicaid reimbursement for telehealth services at the IHS OMB rates.   ***TSGAC Actions:***   1. Creation of a Medicare Telehealth Brief highlighting new reimbursable services through the PHE and after the PHE. Brief was created and shared with TSGAC and Self-Governance Tribes on July 12, 2021. 2. Identify a list of Medicare telehealth services that must be in parity with face-to-face reimbursement. | * **Telehealth Resources for Providers:** <https://www.telehealth.hhs.gov/providers/> * **Medicare Telehealth FAQs:**   <https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf>   * **Medicaid/CHIP Telehealth Toolkit:** <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf> |
| 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.   CHAP Readiness Assessment Program being operated by IHS through a contractor. Contractor is working on a toolkit to address five key factors: training/ed; recruitment; reimbursement; staffing challenges; and roles.  Expected completion by FY 2022 end. | | [**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. Brief was developed and shared on 9/27/2021. * IHS consulting and reporting progress on CHAP Readiness Assessment Program through the CHAP TAG. | * 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. * IHS has pledged to respond in writing to these issues, but TSGAC has yet to receive a response. |

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| MEDICARE PRIORITIES | | | |
| Medicare Part C Payments by Medicare Advantage  *CMS* | ***Issue:*** Medicare Advantage plans are not reimbursing IHCPs at the IHS OMB rates, and often refuse to reimburse at all.  ***Issue:*** According to CMS, if the provider is a closed HMO (like Kaiser) then the HMO does not have to pay. However, if the provider is a PPO managed care entity then they pay BUT at the contract rate. According to CMS staff, Section 206 gives the Tribe the right to be reimbursed, but they are working on at what rate  ***Issue:*** The TTAG has discussed the predatory enrollment of AI/AN elders by Part C plans. Once tribal elders are switched to part C plans, many are ineligible for PRC if the Part C plan directs them to get primary care services from a non-tribal provider. | ***Tribal Recommendations:***   1. Can we require the Medicare Advantage (MA) plans to pay the OMB rate? 2. Tribes have the right of recovery under IHCIA Sec. 206. Request to revisit the issue with OGC and IHS.   ***TSGAC Actions:***   1. Request that OGC and IHS look at this issue to see if we can require payment at the OMB rate and if there is a statutory fix needed. 2. Request for CMS to create guidance for reimbursement to Tribes on MA plans. 3. Request development of an I/T/U addendum for Tribes to negotiate a rate and be included in the plan network to encourage. 4. Follow up with Christine Reinhard, DSCM, MCAG, from CMS who committed to looking into issues with predatory enrollment of elders. | * Staff who work on Part C policy went over these issues with the TTAG and reported there will be a follow-up call with Part C staff and CMS Tribal Affairs to find a policy solution. |
| Medicare Part D Reimbursement  *CMS* | ***Issue:*** Medicare Part D claims being denied as non-payable claims, which impacts compliance on DIR fees for standards of care then cascades to program fees on compliance.  ***Issue:*** Problematic on how the standards of care are gathered on how Tribal pharmacies provide Part D medications. | ***Tribal Recommendations:***   1. Tribal pharmacies are entitled to reimbursement. 2. Adjusting the I/T/U addendum for Part D contracts, which is also a system fix. 3. Need a way to mark I/T/U facility NPI numbers.   ***TSGAC Actions:***  Advocate for an administrative solution to override the compliance denial issue.  *Participate in any edits to Part D Addendum* | * IHS ORAP is considering whether to make edits to the Part D Addendum. IHS stated they will not negotiate a new Addendum with CMS without tribal participation. |
| Medicare Part B Penalties Relief *CMS* | ***Issue:*** Medicare Part B imposes penalties for individuals who delay enrollment once they are eligible. Currently, there are no exceptions for individuals who are eligible for care from the IHS, even though they are like beneficiaries of employment-based insurance plans and do not need additional coverage. | ***Tribal Recommendations:***   1. Request for a regulatory change for AI/AN individuals should be exempt from part B premiums and at a minimum IHS coverage should be deemed creditable coverage so AI/AN enrollees in Part B are not subject to late-enrollment penalties. 2. DTA has stated this will require a legislative fix. | * CMS has concluded a statutory fix is required to deem IHS as credible coverage. |
| Medicare Part B Tribal Sponsorship  *CMS* | ***Issue:*** States can pay Medicare the cost of the Part B premiums, however, Tribes are not able to do this. Currently, Tribes can reimburse individuals for the cost of Part B premiums, but the Medicare beneficiaries have to pay the premiums first. | ***Tribal Recommendations:***  Tribes must be able to sponsor and directly pay for Part B premiums for their Tribal members and pay in one lump sum similar to states and local governments. | * CMS’ Office of General Counsel (OGC) determined a legislative fix will be necessary to allow premium direct sponsorship. |
| Chapter 19 Medicare Claims Processing Manual Revisions  *CMS* | Chapter 19 of the Medicare Claims Processing Manual is out-of-date and includes internal inconsistencies, which has led to billing disputes with Novitas. | ***Tribal Recommendations:***  CMS has obtained the TTAG’s edits to the billing manual. CMS will be providing a revised version for the TTAG to review. |  |
| Provider Based Billing Issue | Many Tribal clinics are not able to bill as provider based to a hospital while others are based on outdated guidance. | ***Tribal Recommendations:***  Tribes have requested that CMS finally fix this issue and allow any tribal clinic that requests it to bill as provider based at the IHS OMB rates | CMS has received a letter on this from the CMS TTAG is going to respond. |

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| MEDICAID PRIORITIES | | | |
| Managed Care  *CMS* | ***Issue:*** IHCPs continue to have difficulty being paid correctly by Medicaid Managed Care organizations (MCOs). States don’t do enough to enforce the requirements (42 C.F.R. § 438.14) and CMS has not done enough to address these issues.  A report from the Tribal Medicaid Managed Care Roundtable, which is currently under review by the TTAG Managed Care Subcommittee, event speakers, and CMS, will be released to the TTAG for approval. | ***Tribal Recommendations:***   1. 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. 2. CMS should require all MA plans to automatically deem Indian health care providers as in-network even if they do not enroll in a provider agreement. 3. Utilization of a Tribal Template for MCO contract (i.e. based off of contract language from Washington and/or California). | * CMS is rethinking the Managed Care Oversight infrastructure. * 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 DTA to determine if there is a violation of MC rules. It will track the issues, have a point of contact and this will expedite resolutions. * CMS sponsored a Medicaid Managed Care Roundtable highlighting best practices (report is forthcoming). |
| Four Walls *CMS* | ***Issue:*** CMS’s grace period for compliance with the “4 walls” restriction for Medicaid clinic services will expire on October 31, 2021.  ***Issue:*** Need for re-interpretation because the services and reimbursement are not the same under an FQHC status versus a tribal clinic. | ***Tribal Recommendations***   * Re-evaluate four walls interpretation due to the differences between reimbursement for services under FQHC versus a Tribal clinic designations.   **TSGAC Recommendations:**   * CMS stated it would respond in writing to the TTAG’s request that the four walls limitation be reinterpreted. | * CMS has requested feedback from Tribes on whether the Tribal Medicaid FQHC workaround is working for Tribes, and if not, why not. |
| 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. | ***Tribal Recommendations:***   1. Continue to gather and report Marketplace metrics including returning to the regular year-end (November) reports. 2. Analyze reduced net premium costs for Marketplace coverage under the American Rescue Plan Act. 3. Continue to work with TTAG on identification of helpful adjustments or additions, including on-screen notices that appear during the Marketplace Application process. 4. Expansion of subsidies to present more opportunities to enroll. 5. Enhance premium sponsorship.   ***TSGAC Actions:***   1. Follow the CMS and IRS implementation plan on the American Rescue Plan provisions with significant increases in premium subsidies. These provisions will be a significant increase in resources to enroll in the exchanges. 2. Educate Tribes and Tribal members on recent changes on HealthCare.gov where Tribal members are informed of not enrolling in the same Marketplace plan with non-Tribal members to maintain cost-sharing protections. 3. Request a significant outreach effort for AI/ANs because the value in plans will significantly improve. Including flexible funding for Tribal Navigators. 4. Educate Tribal employers of the opportunity to consider use of Marketplace for coverage of Tribal employees to reduce premiums and provide access to Indian-specific cost-sharing protections for Tribal members. | * 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. |

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| VA PRIORITIES | | | |
| 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. 5. VA is developing separate IHS and tribal agreements to implement PRC reimbursement. Tribes need to be involved in negotiation of the tribal agreement. | [**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. * 1/13/2022, the U.S. Department of Veterans Affairs (VA) held its second listening session on its efforts to update the VA's Indian Health Service/Tribal Health Program (IHS/THP) Reimbursement Agreement Program in accordance with the Proper and Reimbursed Care for Native Veterans Act (Pub. L. No. 116-311). Written comments may be submitted to tribalgovernmentconsultation@va.gov before February 13, 2022. * VA is drafting a new agreement with tribes to implement PRC reimbursement. Tribes need to be part of negotiating that agreement.   ***TSGAC Actions:***   * 5/28/21: TSGAC submitted comments on VA Tribal Consultation Identification- Documentation for AI/AN Veteran Exemption from Collection of Healthcare Copayments. * 3/2/21: TSGAC submitted comments on the IHS and VA Draft Revised MOU | * VA reports that 116 Tribal Health Programs have individual reimbursement agreements with the VA/VHA. The agreements vary immensely. |