Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

TSGAC ACA/IHCIA Project Priority Issues

Updated: 2/16/2024

	TOPIC/ISSUE	CURRENT STATUS/UPDATES	RECOMMENDATIONS/ NEXT STEPS
1.	***Medicaid Unwinding:*** *In March 2020, the Families First Coronavirus Response Act (FFCRA) provided a temporary increase in the federal match that state Medicaid programs would receive, but it required states meet certain conditions. One of the conditions States had to meet was to keep all Medicaid beneficiaries enrolled in the Medicaid program through the end of the Public Health Emergency. This meant States stopped conducting annual Medicaid eligibility redeterminations.* *In the Consolidated Appropriations Act of 2023, Congress required States to start conducting Medicaid eligibility redeterminations. States were allowed to begin disenrolling Medicaid beneficiaries on April 1, 2023 and are required to complete disenrolling ineligible Medicaid beneficiaries by April 30, 2024.* *The unwinding process is resulting in many people getting disenrolled from Medicaid. Millions have lost coverage not because they are not eligible, but because they did not respond to requests from their Medicaid program. This is a serious issue in Indian country.*	In September/October 2023, the TSGAC developed and sent a survey to the Self-Governance Tribes to gather as much information about how the Medicaid eligibility redetermination process is impacting Indian country. An Executive Summary of the results was compiled and circulated. See website for report: TSGAC-Issue-Brief-Summary-of-Medicaid-Unwinding-Survey-FINAL-dated-12.01.2023.pdf (tribalselfgov.org) The TSGAC shared this information with CMS and their Unwinding team, which is using the information to address issues state by state.	The TSGAC has prepared a new survey, which will be distributed to tribes so we can continue to monitor disenrollments as closely as possible. The TSGAC will continue to share the best practices and other important tools at the Tribal level that seem to be working well. The TSGAC will continue to work with other CMS and other Tribal national organizations to share the various Medicaid Unwinding Toolkits and the most up-to-date information that is available for Tribes in working with their respective states.

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2.	***Opportunities for Tribal Sponsorship (Reimbursement of Marketplace Premiums and Medicare Parts B & D):*** *The Affordable Care Act provides an opportunity for any Tribe to establish a Tribally-Sponsored program to purchase health insurance coverage **("Tribal Sponsorship")** for their uninsured Tribal members through a Health Insurance Marketplace. Tribes may also choose to pay Medicare Part B and Part D premiums through a Tribal Sponsorship program. The Indian Health Care Improvement Act specifically authorizes that Tribes may use funds made available under the Indian Self-Determination and Education Assistance Act (ISDEAA) to purchase health coverage for Tribal members.*	In October 2023, the TSGAC developed and sent a survey to the Self-Governance Tribes to collect data about the benefits, barriers, and other important factors which influence Tribes' engagement in Tribal Sponsorship programs. The TSGAC updated and posted a Tribal Sponsorship toolkit on its website: Tribal Sponsorship Tool Kit - Tribal Self-Governance (tribalselfgov.org)	The TSGAC is currently drafting an Executive Summary of the findings. Initial results indicate a huge need for additional training. As part of the ACA/IHICIA Work Plan for FY2024, the TSGAC intends to conduct on-site training(s). A break-out session is also planned for the 2024 Tribal Self-Governance Conference scheduled in April 2024.
3.	***CHAP:*** *The CHAP is a Tribally-driven multidisciplinary mid-level primary health provider model of community, behavioral, and dental health professionals working alongside state licensed providers at the front line of health care for Tribal communities. The CHAP includes community health aides/practitioners (CHA/Ps), behavioral health aides/practitioners (BHA/Ps), and dental health aides/therapists (DHA/Ts).* *The CHAP has evolved since Congress made CHAP a permanent program in Alaska in 1992. CHAP provides an opportunity to expand Tribal Self-Determination and Self-Governance by utilizing Tribal community expertise and knowledge to expand health care services through culturally-based care. CHAP nationalization can be utilized to expand access to care and holds promise as a mechanism to overcome provider recruitment and retention barriers.*	CHAP implementation done the right way is an exercise of tribal self-determination and tribal self-governance.	Continue to monitor CHAP implementation (in collaboration with CHAP TAG) Continue to echo support for building a CHAP that is rooted in indigenous people and traditions and as an opportunity for tribes to self-determine in partnership with IHS a health care system that meets the needs of tribal communities. Collaborate with CHAP TAG to hold IHS accountable to the promise of CHAP with the lens of self-determination, self-governance, and tribal sovereignty.

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			A break-out session is planned for the 2024 Tribal Self-Governance Conference scheduled in April 2024
4.	***Pharmacy Reimbursements (also see Item #7 under CMS/TTAG Small Workgroup Issues):*** *Tribes are having problems with PBMs not paying them, or not paying them correctly for drugs. This is occurring both in the Part D program, and also with PBMs operating private drug insurance programs. Addressing this issue is a TTAG priority.*	Tribal representatives under a separate IHS/Tribal Workgroup have been working with IHS to develop a new Part D addendum that would require PBMs to pay Tribes correctly.	A draft Part D Addendum has been proposed and sent to CMS by IHS for review. Currently, the Part D addendum only applies to Part D plans, but Tribes are proposing to make it applicable to all PBMs.

Coordination with TTAG/CMS Small Workgroups on Medicare/Medicaid Administrative/Regulatory Issues

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1.	***Medicaid Priority #1: Encourage States to Authorize Medicaid Telehealth Reimbursement for Indian Health Care Providers at the OMB Encounter Rate*** *States have broad authority to authorize reimbursement for telehealth services and many States reimburse for telehealth services at the same rates as in-person services.*	***TTAG Request:*** *CMS should issue specific written guidance to States (e.g., a State Health Officials Letter or CMS Informational Bulletin) confirming that they can reimburse telehealth services at the IHS OMB encounter rates, not only during the PHE but also permanently.*
2.	***Medicaid Priority #3: Revisit Four Walls Interpretation*** *CMS has interpreted the Medicaid clinic benefit to exclude services furnished offsite by clinic staff, except to homeless individuals. IHS and tribal programs that are enrolled in Medicaid as providers of clinic services have long provided, and been reimbursed by the Medicaid program for, services provided by their staff outside the physical four walls of the facility, including vital services they have furnished for decades at the off-site locations where they are most effective, such as schools, community centers, patients' homes, and by mobile crisis response teams. CMS clearly*	***TTAG Request:*** *CMS has the authority to interpret the clinic benefit more broadly, to include offsite services furnished to all clinic patients. CMS's current interpretation of the benefit, in our view, is based on a misreading of the Social Security Act and CMS's regulations, and it is profoundly contrary to the public health, especially in the wake of the COVID-19 pandemic. We request that CMS revisit and revise its interpretation.*

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	recognizes the adverse impacts of this cramped interpretation of the statute and has worked to mitigate them, by granting and extending an enforcement grace-period, and allowing tribal clinics to be redesignated as "FQHCs," which have no four-walls restriction. However, the four walls option has not been implemented by all states with tribal programs, and even in States that have taken it up, the option leaves out some services and is completely unavailable to programs operated directly by the Indian Health Service.	**UPDATE** – CMS is considering addressing this issue in an upcoming proposed rule. The TSGAC will continue to monitor and share information as this develops.
3.	***Medicaid Priority #4: Shield IHCP's from state benefit cuts or enrollment limitations*** *The TTAG is concerned that some States will soon consider cutting their Medicaid program benefits and enrollment rates, as the nation grapples with an economic downturn and the States face the eventual loss of the enhanced federal Medicaid payment rates they have received during the COVID-19 Public Health Emergency. Even though States receive 100% FMAP for Medicaid services furnished by Indian providers to Indian Health Service beneficiaries, they generally cover tribal programs and AI/AN patients only for the same Medicaid services as other providers and patients. Tribal programs and AI/ANs rely disproportionately on Medicaid services and reimbursements, and they will suffer disproportionately if Medicaid programs are cut with no exception for them. CMS has the authority, under Section 1115, to grant State waiver requests to shield tribal health programs and AI/AN beneficiaries from Medicaid cuts, and has exercised this authority in the past.*	***TTAG Request:*** *CMS to encourage States to apply for such waivers, to create specific guidance and templates States could follow, and to liberally grant State waiver requests, given the vital role Medicaid plays in meeting the federal Trust Responsibility for Indian Health and to reducing long-standing health disparities AI/ANs suffer as a result of colonization, systemic racism, and federal policies that fail to respect tribal sovereignty.*

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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. CMS should require all MA plans to automatically deem Indian health care providers as in-network for reimbursement purposes, even if they do not enroll in a provider agreement. Section 206 of the IHCIA (42 U.S.C. 1621e) gives Indian health care providers the right to recover their reasonable costs from certain third parties, including Medicare Advantage plans, regardless of whether they are in-network or not. As a cost-based rate, the IHS OMB rate at the very least should be considered "reasonable costs" for purposes of Section 206.*	***TTAG request****: CMS to develop and implement a Part C Indian Addendum that requires Medicare Advantage plans to reimburse Indian health care providers at the OMB rates.*
5.	***Increase Flexibility in Medicare Definition of Telemedicine Services*** *COVID-19 made it necessary for the Medicare program to cover more telehealth services to allow access to providers during the pandemic. But it has also demonstrated the general safety and effectiveness of telemedicine, 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. The telehealth flexibilities Medicare has made available during the public health emergency should be made permanent to the maximum extent possible, and more services should be allowed to be furnished via telehealth.*	***The Medicare telehealth flexibilities were extended through FY2024 in the FY2023 Omnibus bill.*** ***TTAG request:*** *CMS provide maximum flexibility in the implementation of these Medicare telehealth flexibilities and make them permanent.*
6.	***Make the IHS Outpatient Encounter Rate Available to All Indian Outpatient Programs Who Request It*** *For many years, the TTAG has been urging Medicare to allow all Indian outpatient programs the option to bill at the same IHS-established and OMB-approved encounter rates that would apply if the programs were directly operated by the IHS. Under current Medicare regulations and policies, programs operated by Tribes and Tribal Organizations under the Indian Self-Determination and Education Assistance Act may lose access to that rate, depending almost entirely on whether and when the program was last operated by the IHS or affiliated with an IHS operated hospital. Regardless of how similar or different they may otherwise be, Indian*	***TTAG request:*** *CMS should adopt a new Medicare regulation, or amend its tribal provider-based and grandfathered tribal FQHC rules at 42 C.F.R. § 413.65(m) and 42 C.F.R. § 405.2462, to allow all Indian outpatient programs that request it to be paid for all Medicare-covered services at the IHS Outpatient encounter rate, and without irrelevant or additional cost-reporting requirements.*

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	outpatient programs are now paid by Medicare at dramatically different rates, depending on whether they are operated by a Tribe or the IHS or qualify as a "provider-based facility," a "grandfathered Tribal FQHC," a non-grandfathered Tribal FQHC, or none of the above. In effect, Indian Tribes and Tribal Organizations are now financially penalized by the Medicare program for exercising their Indian Self-Determination Act rights, and their ability to provide a wide range of high-quality services to their AI/AN patients is compromised.	
7.	***Medicare Part D Reimbursement*** *Tribal facilities across the country are getting hit with steep discounts in their reimbursements from pharmacy benefit managers (PBMs) based on tribes' ability to access drugs at discount rates under programs like the 340B program and VA prime vendor and due to Part D Direct and Indirect Remuneration (DIR) fees. PBMs are asking tribal facilities if they are accessing discounted pharmaceuticals, such as under the 340B program, and then discounting reimbursements based on the amount of the discount. PBMs are also reducing payments instead of passing along bonuses when they receive DIR fees. These efforts effectively take these benefits away from tribes and keeps them for the PBMs. Performance metrics being reported to CMS for IHS and Tribal facilities are also negatively affected, as PBMs inaccurately report low performance for medication adherence if the Part D program does not pay for the prescription.*	***TTAG Request:*** *TTAG is developing a new Part D Addendum that would address these issues and request CMS to adopt same.*