| Lead Agency: SHORT TITLE **Reference Number; Title of Reg/Agency Action** | **Summary of Action** | **Notes** |
| --- | --- | --- |
| **Centers for Medicare & Medicaid Services (CMS): Priority Roster Items** | | |
| ***CMS Proposed Rule***  **Benefit and Payment Parameters; Notice Requirement for Non-Federal Governmental Plans**  **CMS-9916-P**  **RIN: 0938-AT98**  <https://www.federalregister.gov/documents/2020/02/06/2020-02021/benefit-and-payment-parameters-notice-requirement-for-non-federal-governmental-plans>  **Comment deadline: 03/02/2020** | **Summary** Each year HHS make various adjustments and updates to rules pertaining to the [Affordable Care Act](https://www.healthinsurance.org/obamacare-the-affordable-care-act/). This proposal is for 2021.  * CMS seeks comments on whether it should end automatic re-enrollment for low-income exchange enrollees who receive $0 premium plans with tax credits (i.e, after advance payments of the premium tax credit (APTC) are applied). CMS asks whether it should discontinue or reduce those enrollees' advanced premium tax credits for the next year unless they actively update their application during open enrollment. The change is mean to reduce the risk that ineligible enrollees receive federal subsidies. * CMS is also considering an alternative approach, where APTC for this population would be reduced to a level that would result in an enrollee premium that is greater than zero dollars, but not eliminated entirely. This would be to make sure of consumers’ active enrollment: a plan with a premium that is greater than zero would require the enrollee to take an action by making the premium payment to effectuate or maintain coverage, or else face eventual termination of coverage for non-payment. * CMS asks the public to identify risks of auto-enrollment and suggests that it will conduct consumer outreach and education alerting consumers to the new process and emphasizing the importance of returning to the Exchange during open enrollment to update their application to “ensure that their income and other information is correct and that they are still in the best plan for their needs.” * Proposal includes higher out-of-pocket caps for health insurance plans. * CMS is also proposing a rule change to eliminate the requirement that people with most special enrollment periods [sign up by the 15th of the month](https://www.healthinsurance.org/obamacare/qualifying-events-that-can-get-you-coverage/#QLE) to get coverage effective the first day of the following month. | **Notes**  **Fact Sheet**  <https://www.cms.gov/files/document/proposed-2021-hhs-notice-benefit-and-payment-parameters-fact-sheet.pdf>  CMS admits that auto-enrollment reduces the numbers of uninsured, lowers premiums and stabilizes risk pools, but is concerned about incorrect APTC expenditures.  Potential Tribal impact:  **Burden on enrollment assisters.** Many, if not most American Indians and Alaska Natives have traditionally be very adverse to enrollment in paid health insurance, yet, when consumers are enrolled in a plan that they like, auto enrollment makes everything easier. Auto enrollment simplifies the tasks of enrollment assisters, who ask AI/ANs to meet with them at the end of the year to go over whether their plan premiums changed or if there are any other differences. Some people do not make it in to see the Enrollment Assister; or do not check mail (this reg proposes mail as one way to conduct outreach); and are not aware of whether a plan changed from one year to the next. For this reason, ending auto-enrollment for AI/ANs would put a great burden on our enrollment assisters.  **A note on reduction of user fees.** The agency is considering lowering user fees (FFE and state-bases exchanges) below the 2020 plan year levels to “reflect estimates of premium increases and enrollment decreases for the 2021 benefit year, reduce user burdens.” However, funds collected through user fees are used for outreach and education purposes. Should it implement the change to auto-enrollment, CMS indicates that O&E would be necessary. This is particularly important to Tribal communities that may not have easy access to enrollment assisters or technology to receive notice of plan changes.  **Recommendation: Exempt American Indians and Alaska Natives from the disenrollment process.** |
| ***CMS Request for Information***  **Coordinating Care From Out-of-State Providers for Medicaid-Eligible Children With Medically Complex Conditions**  **CMS-2324-NC**  **RIN: 0938-ZB57**  <https://www.federalregister.gov/documents/2020/01/21/2020-00796/coordinating-care-from-out-of-state-providers-for-medicaid-eligible-children-with-medically-complex>  **Comment deadline: 03/23/2020** | **Summary**  Background. The Medicaid Services Investment and Accountability Act of 2019 (MSIA), added section 1945A to the Social Security Act, under which states have the option to cover health home services for Medicaid-eligible children with medically complex conditions. This option will be available to states beginning Oct. 1, 2022, after HHS solicits public feedback to create guidance.  RFI. CMS requests input from rural and urban advocates, caregivers, providers, and States on best practices for using out-of-state providers to care for Medicaid-eligible children with medically complex conditions. Input may address how to coordinate care when providers are out-of-state; how to reduce barriers from receiving out-of-state care in a timely fashion; and best practices for screening and enrolling out-of-state providers in Medicaid.  Responses to this request will inform efforts to craft guidance to state Medicaid directors, which the agency expects to publish by October 1, 2020 as required by section 1945A(e)(2) of Social Security Act, as added by the Medicaid Services Investment and Accountability Act (MSIA) of 2019.  In addition to children, their families and states, CMS seeks input from providers (children’s hospitals, pediatricians), managed care plans, children’s health groups, and family and beneficiary advocates.  MSIA clearly defines eligibility for children younger than 21 with medical complexity as having:   * One or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning – such as the ability to eat, drink, or breathe independently – and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or * One life-limiting illness or rare pediatric disease, as defined in section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act.   More on MSIA [here](https://nashp.org/new-medicaid-funding-could-help-states-better-integrate-care-for-children-with-medical-complexity/). | **Notes**  CMS is soliciting feedback on a number of questions, including:   * **Barriers to receiving care.** Administrative, fiscal, and regulatory barriers that states, providers, beneficiaries, and their families experience that prevent children with medically complex conditions from timely receiving care (such as community and social support services), from out-of-state providers. * **Screening and enrolling out of state Medicaid providers.** What processes states could use to streamlines or reduce the administrative and fiscal burden on out-of-state providers and states (emergency and non-emergency situations). * **Access to quality care.** Challenges with referrals to out-of-state providers for specialty services, including community and social supports, for children with medically complex conditions and the impact of these challenges on access to qualified providers. * **Payment rates for out of state providers.** Best practices for developing appropriate and reasonable terms of contracts and payment rates for out-of-state providers, for both Medicaid fee-for-service and Medicaid managed care.   As of 2015, care coordination is the most frequently provided health home service, but not all enrollees automatically receive it.  Potential Tribal Impact  AI/ANs tend to live in child health care “[deserts](https://www.americanprogress.org/issues/early-childhood/reports/2018/12/06/461643/americas-child-care-deserts-2018/)” and so there is a deep need for high quality child care in these regions. The reality is that Tribes have to cross borders to receive care, so this is an especially important rule for Tribes who straddle two or more state borders, such as those in California, and the Navajo Nation (Gallup Medical Center).  **Flashback:** Do MMPC/TTAG members recall discussing this issue in the TTAG Across State Borders Subcommittee? |
| ***CMS Proposed Rule***  **Basic Health Program; Federal Funding Methodology for Program Year 2021**  **CMS-2432-PN**  **RIN: 0938-ZB56**  <https://www.federalregister.gov/documents/2020/02/10/2020-02472/basic-health-program-federal-funding-methodology-for-program-year-2021>  **Comment deadline: 03/11/2020** | Summary CMS published a proposed methodology to determine the federal payment amounts for the program year 2021 to states that elect to establish a Basic Health Program under the Affordable Care Act.  The Basic Health Program (BHP) makes health benefit coverage affordable to those under age 65 with household incomes between 133 percent and 200 percent of the Federal Poverty Level and to others that qualify.  This methodology identifies the specific information required to determine federal payments for the BHP by using previous data and assumptions that reflect ongoing operations, experience of BHPs and the operation of the Exchanges. Rate cells for each state, a unique combination of age range, geographic area and other aspects, will also be used to calculate federal payment amounts and premium tax credit (PTC) for the BHP.  The 2020 payment methodology is the same methodology as the 2019 payment methodology with one additional adjustment to account for the impact of individuals selecting different metal tier level plans in the Exchange, referred to as the Metal Tier Selection Factor (MTSF).  **The change for the 2021 Regulation:**  This year, **CMS proposes to apply the same payment methodology** that is applied to program year 2020 to program year 2021, **with one modification to the calculation of the income reconciliation factor (IRF).**  CMS just released it’s Basic Health Program; Federal Funding Methodology for Program Years 2019 and 2020  <https://www.federalregister.gov/documents/2019/11/05/2019-24064/basic-health-program-federal-funding-methodology-for-program-years-2019-and-2020> | **Notes**  Tribal impact TTAG [commented](https://www.nihb.org/tribalhealthreform/wp-content/uploads/2019/05/TTAG-Comment-Letter-on-BHP-Proposed-Methodology.pdf) on the 2019-2020 proposed methodology last year (May 2, 2019). CMS recently released the BHP Final Rule and responded to two of TTAG’s comments:  **Reference Premium for CSR Calculation**  **TTAG recommendation:** CMS should modify the assumption used with regard to the selection of QHPs by AI/ANs. The TTAG recommends that CMS assume that AI/ANs who enroll in coverage through an Exchange will enroll in the second lowest-cost bronze plan.  **Agency response:** CMS noted that Section 1331(a)(2)(A)(i) of the ACA requires that states operating BHPs must ensure that individuals do not pay a higher monthly premium than they would have if they had been enrolled in the second lowest cost silver-level QHP in an Exchange, factoring in any PTC individuals would have received.  **Premium Tax Credit (PTC) Adjustment**:  **TTAG Recommendation:**  For any AI/AN-specific adjustment in the BHP formula for PTC payments to states, CMS should ensure it accounts for the likelihood that AI/ANs who enroll in a QHP through an Exchange will expend the full value of the PTC available to them. In a previous response, CMS clarified that the methodology as proposed assumes AI/ANs who enroll through the Exchange would choose a QHP with a premium at least equal to the value of the PTC.  **Agency Response:** CMS noted that the only portion of the rate affected by use of the lowest-cost bronze-level QHP is the cost-sharing reduction (CSR) portion of the BHP payment; due to the discontinuance of CSR payments and the accompanying modification to the BHP payment methodology, the CSR portion of the payment is assigned a value of 0, and any change to the assumption about which bronze-level QHP is used would therefore have no effect on the BHP payments.  **Questions to asking moving forward:** Do we think that other states will adopt a basic health plan? Perhaps not, since states are looking more at the 1332 fee waivers, alternative to Medicaid funding and Medicaid expansion. Still, this is an issue to monitor on behalf of Tribes. NIHB will do follow-up with Minnesota contact on this matter. |
| ***CMS Proposed Rule***  **Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021**  **CMS-9916-P**  **RIN: 0938-AT98**  <https://www.federalregister.gov/documents/2020/02/06/2020-02021/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021>  **Comment deadline:**  **03/02/2020** | **Summary**  CMS released the proposed annual Notice of Benefit and Payment Parameters Rule for 2021, also known as the proposed 2021 Payment Notice. This is the second year in a row that the proposed rule has been late (this year it came out in late January).  CMS is proposing changes to the policy regarding how drug manufacturer coupons accrue towards the annual limitation on cost sharing in response to stakeholder feedback indicating Treatment of Drug Manufacturer Coupons. CMS is proposing to amend current Medical Loss Ratio (MLR) regulations to require issuers to deduct from incurred claims the prescription drug rebates and other price concessions attributable to the issuer’s enrollees and received and retained by an entity providing pharmacy benefit management services to the issuer. CMS also proposes to clarify more generally that issuers must report expenses for services outsourced to or provided by other entities in the same manner as issuers’ expenses for non-outsourced services. These changes would help lower premiums by helping ensure that consumers’ premiums reflect the full benefit of prescription drug rebates and are not artificially inflated by outsourcing expenses.  CMS proposes to maintain the Federally Facilitated Exchange (FFE) user fee rate of 3.0 percent of premium, and the State-based Exchange on the Federal Platform (SBE-FP) user fee rate of 2.5 percent of premium based on the portion of FFE user fee-eligible costs allocated to SBE-FP activities. Alternatively, CMS is considering and seeking comment on reducing the FFE and SBE-FP user fee rate below the 2020 plan year level to reflect estimates of premium increases and enrollment decreases for the 2021 plan year, as well as potential savings resulting from cost-saving measures implemented over the last several years in hopes of reducing the user fee burden on consumers and creating downward pressure on premiums. | **Notes**  Tribal impact  MMPC most recently commented on the Notice of Benefit and Payment Parameters for 2018 (here is the letter): <https://www.nihb.org/tribalhealthreform/wp-content/uploads/2016/10/NIHB-comments-on-CMS-9934-P-2016-09-29c.pdf>)  This rule addresses AIANs when it addresses **special enrollment periods:**  “Section 1311(c)(6)(C) of the PPACA establishes special enrollment periods and section 1311(c)(6)(D) of the PPACA establishes the monthly enrollment period for Indians, as defined by section 4 of the Indian Health Care Improvement Act”  And **reductions in cost sharing:**  “Section 1402 of the PPACA provides for, among other things, reductions in cost-sharing for EHB for qualified low- and moderate-income enrollees in silver level health plans offered through the individual market Exchanges. This section also provides for reductions in cost sharing for Indians enrolled in QHPs at any metal level.”  **Recommendation: If we move forward with comments, likely we will reiterate these same points. TAs are in the process of analyzing this regulation.** |
| ***CMS Proposed Rule***  **Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly**  **CMS-4190-P**  **RIN 0938-AT97**  <https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-02085.pdf>  **Comment deadline: 04/06/2020** | **Summary**  CMS is proposing change to the Medicare Advantage and Medicare Part D programs, including implementing various provisions of the SUPPORT Act and 21st Century Cures Act.  **MA Plans:**   * CMS proposes changes to the medical loss ratio methodology by broadening the definition of incurred claims. * Update the MA network adequacy standards to incentivize MA plans to contract with certain telehealth providers and expand access to MA plans in counties where network development can be challenging, such as rural areas. * Specifically, CMS proposes to allow MA plans to receive a 10% credit toward the percentage of beneficiaries residing within published time and distance standards when they contract with certain telehealth providers and reduce the required percentage of beneficiaries residing within maximum time and distance standards in certain county types (Micro, Rural, and Counties with Extreme Access Considerations). * CMS also proposes to codify the MA network adequacy methodology and standards. For Part D plans, CMS proposes to mandate Drug Management Programs, modify the definition of opioid-at-risk Part D beneficiaries for inclusion in DMPs, and require Part D plans to implement a beneficiary real-time benefit tool. | **Notes**  **Fact Sheet**  <https://www.cms.gov/newsroom/fact-sheets/contract-year-2021-and-2022-medicare-advantage-and-part-d-proposed-rule-cms-4190-p-1> |
| ***HHS and FDA Proposed Rule***  **Proposed Rule on Canadian Drug Importation Plan**  **RIN: 0910-AI45**  <https://www.federalregister.gov/documents/2019/12/23/2019-27474/importation-of-prescription-drugs>  **Comment deadline:**  **03/09/2020** | **Summary**  In December, theDepartment of Health and Human Services (HHS) and the Food and Drug Administration (FDA) released a draft guidance on the importation of certain prescription drug imports from Canada, leaving out many specialty medications and other therapies for chronic diseases that cost patients the most.  **The FDA seeks request for comment on two importation pathways.**   1. One would allow states to submit proposals to the FDA to allow the importation of small molecule brand-name medicines sold at retail pharmacies, typically ones that have rebates attached to them. The draft guidance for industry lets manufacturers import the same versions of FDA-approved drugs they now sell in foreign countries. 2. Under this second pathway, drug manufacturers would use a new National Drug Code (NDC) and sell these drugs in the U.S. at a cheaper price.   FDA is also seeking comments on Draft industry Guidance. See Notes section🡪 | **Notes**  The Regulatory Impact Analysis for the Proposed Rule can be found here:  <https://www.fda.gov/about-fda/economic-impact-analyses-fda-regulations/importation-prescription-drugs-proposed-rule-regulatory-impact-analysis>  FDA is also announcing the availability of a draft guidance that describes procedures to obtain an additional National Drug Code for an FDA-approved prescription drug that is imported into the United States in compliance with section 801 of the FD&C Act.  **Find the Draft Guidance Here:**  <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/importation-certain-fda-approved-human-prescription-drugs-including-biological-products-under>  **Comment deadline for the Guidance is 02/21/2020.** |
| **Indian Health Service** | | |
| **Dear Tribal Leader Letter** Tribes Notified of Possible Public Health Service Corps Officer Deployment due to Coronavirus <https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_DUIOLL_02062020.pdf> | **Summary**  On February 6, the Indian Health Service (IHS), issued an authorization and [notice](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_DUIOLL_02062020.pdf) on the possibility of deployment for Corps officers in the U.S. Public Health Service due to the rapid spread of the 2019 Coronavirus. Corps officers play a vital role in the U.S. Department of Health and Human Services (HHS), particularly as part of the Emergency Support Function (ESF) #8 role in supplementing Tribes, states, and others the resources in response to public health emergencies. This includes incidents with international implications. The HHS Secretary and Assistant Secretary for Health (ASH) have begun to implement Corps participation in ESF #8 activities through outbreak expertise and guidance to health care professionals, conducting passenger screening at U.S. airports and borders, and providing logistical and technical support, as needed. To ensure the availability of the greatest number of assets, the ASH has exercised his authority in Commissioned Corps Directive (CCD) 121.02 “Deployment and Readiness” (<https://dcp.psc.gov/ccmis/ccis/documents/CCD_121.02.pdf>) to deploy Corps officers assigned to HHS Operating and Staff Divisions without supervisory or agency approval.  Since the deployment of Corps officers at any moment stands to put Tribes in a difficult situation, the IHS commits to working closely with Tribes to assist as much as possible with solutions for backfilling Corps officers who are deployed. **Those with questions or concerns are encouraged to contact CAPT Angela Mtungwa, Director, Division of Commissioned Personnel Support, IHS, by e-mail at** [angela.mtungwa@ihs.gov](mailto:angela.mtungwa@ihs.gov)**, or by telephone at (301) 443-5440**. | Notes **Tribes expressed concern about the deployment of corps officers during the Secretary’s Tribal Advisory Committee meeting this month.**  **In light of the coronavirus, Tribal communities are receiving requests for the deployment of pharmacists. This can be hard on the areas, yet corps officers must follow orders and not doing so can deter career mobility.** |

**Regulatory Updates Continued…**

Centers for Medicare & Medicaid Services ([Source](https://www.jdsupra.com/legalnews/washington-healthcare-update-february-89215/))

**CMS:** [**2021 Medicare Advantage Advance Notice Part I – Risk Adjustment**](file:///\\NIHB-SBE\Folder%20Redirection\MMartinez\Desktop\Find%20the%20proposed%20rule%20here.%20Public)

CMS released Part I of the 2021 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (the Advance Notice), which contains key information about proposed updates to the Part C CMS-Hierarchical Condition Categories (HCC) risk adjustment model and the use of encounter data.

Part 1 of the 2021 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies proposes changes to the Part C risk adjustment model and the use of encounter data. Under the proposal, CMS proposes to calculate risk scores for 2021 by using the sum of 75 percent of the risk score calculated with the 2020 CMS-Hierarchical Condition Categories model and 25 percent of the risk score calculated with the 2017 version of the model. For 2020, CMS calculated risk scores using the sum of 50 percent of each model.

CMS also proposed changes to how it uses encounter data, or diagnostic information, in the risk adjustment calculation process. For 2021, CMS wants to calculate risk scores for Medicare Advantage plans by summing 75 percent of the encounter data-based risk score with 25 percent of the Risk Adjustment Processing System-based risk score. For 2020, CMS calculated risk scores using the sum of 50 percent of each type of data. **Comments are due by** **March 6, 2020**.

<https://www.regulations.gov/document?D=CMS-2020-0003-0001>

**CMS: 2021 Medicare Advantage and Part D Advance Notice Part II**

On February 5, CMS released Part II of the Calendar Year (CY) 2021 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (the Advance Notice). The notice is seeking comment on whether it should develop measures of generic and biosimilar utilization that could be used to calculate a plan’s star rating, so CMS could reward plans that encourage adoption of lower-cost products. CMS will accept comments on all proposals in the Advance Notice through March 6, 2020, before publishing the final Rate Announcement by April 6, 2020. Also see the [Fact Sheet](https://www.cms.gov/newsroom/fact-sheets/2021-medicare-advantage-and-part-d-advance-notice-part-ii-fact-sheet-0).

<https://www.cms.gov/files/document/2021-advance-notice-part-ii.pdf>

**CMS and HRSA: Two Proposed Rules for Organ Procurement Organizations (OPOs)**

Two rules were proposed related to organ procurement organizations (OPOs), specifically on performance standards and the promotion of donations from living donors.

**The CMS rule** would revise the Organ Procurement Organization (OPO) Conditions for Coverage (CfCs) to increase donation rates and organ transplantation rates by replacing the current measures with new transparent, reliable, and objective measures. The rule wouldalso hold OPOs accountable for meeting specific performance metrics. The rule uses federal death records, which show the entire pool of potential organ donors, to calculate an OPO’s donation and transplantation rates. In addition, the proposed rule would require all OPOs to meet the donation and transplantation rates of the current top 25 percent of OPOs. CMS will be able to rank the OPOs based on their performance and make that data public, assessing them annually through a re-certification cycle. **Comments due 02/21/2020.**

<https://www.federalregister.gov/documents/2019/12/23/2019-27418/medicare-and-medicaid-programs-organ-procurement-organizations-conditions-for-coverage-revisions-to>

**The Health Resources and Services Administration (HRSA) rule** attempts to eliminate financial burden on living donors. The proposed rule would allow insurers to reimburse living donors for lost wages, as well as any child care or elder care expenses they incurred during their hospitalizations for or recoveries from the donation. **Comments due 02/18/2020.**

<https://www.federalregister.gov/documents/2019/12/20/2019-27532/removing-financial-disincentives-to-living-organ-donation>

Office of the Secretary, Department of Health & Human Services

# Coronavirus Declared Public Health Emergency

On February 7th 2020 HHS published a [notice](https://www.federalregister.gov/documents/2020/02/07/2020-02496/determination-of-public-health-emergency) on the Coronavirus where the Secretary of HHS classified the virus as a public health emergency in that the virus could potentially affect national security or the health and security of United States citizens living abroad. This notice also includes the authorization of emergency use of in vitro diagnostics for diagnosis of the novel coronavirus. **The declaration took effect on 02/04/2020.**

<https://www.federalregister.gov/documents/2020/02/07/2020-02496/determination-of-public-health-emergency>

**STAC Vacancies**

The Department of Health and Human Services (HHS) Secretary’s Tribal Advisory Committee (STAC) currently has vacancies for membership.

The STAC was established in 2010 by HHS in an effort to create a coordinated, Department-wide strategy to incorporate tribal guidance on HHS priorities, policies, and budget.  The STAC’s tribal representation is comprised of seventeen positions: one delegate (and one alternate) from each of the twelve Indian Health Service (IHS) areas and one delegate (and one alternate) for the five National At-Large Members positions.  In working closely with tribal leadership on this committee, the Department has elevated the level of attention given to the government-to-government relationship with Indian tribes and has developed mechanisms for continuous improvement and communication with our partnerships with tribes. Tribes are encouraged to submit nomination letters no later than **March 18, 2020**. Selections will be made and individuals notified by **April 1, 2020**. More information here (PDF):



Indian Health Service

**IHS Notice: Loan Repayment Program for Repayment of Health Professions Educational Loans**

The IHS estimated budget for fiscal year (FY) 2020 includes $34,800,000 for the IHS Loan Repayment Program (LRP) for health professional educational loans (undergraduate and graduate) in return for full-time clinical service as defined in the IHS LRP policy at <https://www.ihs.gov/loanrepayment/policiesandprocedures/> in Indian health programs.

Deadlines: **February 15, 2020, first award cycle deadline date;** August 15, 2020, last award cycle deadline date; September 15, 2020, last award cycle deadline date for supplemental loan repayment program funds; September 30, 2020, entry on duty deadline date.

<https://www.federalregister.gov/documents/2020/02/11/2020-02617/loan-repayment-program-for-repayment-of-health-professions-educational-loans>

**Indian Health Professions Preparatory, Indian Health Professions Pre-Graduate and Indian Health Professions Scholarship Programs**

Approximately 25 new awards will be made by the IHSSP under the Preparatory Scholarship and Pre-graduate Scholarship programs for Indians. The awards are for 10 months in duration, with an additional 2 months for approved summer school requests, and will cover both tuition and fees and other related costs (ORC). The average award to a full-time student in both programs is approximately $40,372.61. Approximately 100 new awards will be made by the IHSSP under the Health Professions Scholarship program. The awards are for 12 months in duration and will cover both tuition and fees and ORC. The average award to a full-time student is approximately $120,814.38. Approximately a total of 300 awards will be made under the IHSSP Scholarship Program for FY 2020-2021. **Application deadline 02/28/20 at 7:00PM ET.**

<https://www.federalregister.gov/documents/2020/02/11/2020-02618/indian-health-professions-preparatory-indian-health-professions-pre-graduate-and-indian-health>

Health Resources and Services Administration (HRSA)

**HRSA comment request: Nurse Corps Loan Repayment Program**   
HRSA has opened an additional 30-day comment period for feedback on a new form and changes to existing forms required during the application process for the NURSE Corps Loan Repayment Program (LRP). The NURSE Corps LRP provides loan repayment assistance to registered nurses, nurse practitioners, advanced practice nurses, and nursing school faculty who agree to work in underserved areas. **Comments due March 03/2/2020.**

<https://www.federalregister.gov/documents/2020/01/30/2020-01713/agency-information-collection-activities-submission-to-omb-for-review-and-approval-public-comment>

**HRSA and HHS meeting on the Secretary’s National Advisory Committee**

HRSA and HHS has scheduled a public meeting for the Secretary’s National Advisory Committee on Rural Health and Human Services. **The meeting will be held 03/02-03/04/2020.**

<https://www.federalregister.gov/documents/2020/01/31/2020-01810/national-advisory-committee-on-rural-health-and-human-services>

# HRSA to Consider Asking Loan Repayment Program Applicants for Additional Education Information

On February 3rd 2020, HRSA sent out a [notice](https://www.federalregister.gov/documents/2020/02/03/2020-01933/agency-information-collection-activities-submission-to-omb-for-review-and-approval-public-comment) requesting public comment on the National Health Service Corps (NHSC) Loan Repayment Program. The program was established to assure an adequate supply of trained primary care health professionals to provide evidence based Substance use disorder (SUD) treatment to health professional shortage areas. Under this notice, information collected will be used to assess a Loan Repayment Program (LRP) applicant’s eligibility to obtain information for NHSC site applications.

**Comments are due 03/04/2020.**

<https://www.federalregister.gov/documents/2020/02/03/2020-01933/agency-information-collection-activities-submission-to-omb-for-review-and-approval-public-comment>

**CDC/HRSA Advisory Committee Meeting on Regency Assay-based Incident Estimation**

The Centers for Disease Control and Prevention (CDC)/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) has scheduled a public meeting to discuss issues related to a CDC pilot on regency assay-based incidence estimation and the President’s initiative on “Ending the HIV Epidemic: A plan for America”. The **meeting will be held on 03/05/2020.**

<https://www.federalregister.gov/documents/2020/01/31/2020-01809/meeting-of-the-cdchrsa-advisory-committee-on-hiv-viral-hepatitis-and-std-prevention-and-treatment>

**HRSA Seeking Information on “Ending the HIV/AIDS Epidemic” (EHE)**

HRSA published a notice on a collection request regarding “Ending the HIV/AIDS Epidemic” (EHE) on the initiative’s funding and it’s specifics related to individuals that have been prescribed antiretroviral medications in the previous four months.  **Comments due 03/09/2020.**

<https://www.federalregister.gov/documents/2020/02/06/2020-02354/agency-information-collection-activities-submission-to-omb-for-review-and-approval-public-comment>

**HRSA Seeks Comment on Dental Reimbursement Program**

HRSA sent out a notice for public comment on their Dental Reimbursement Program (DRP) and the Community Based Dental Partnership Program (CBDPP) in order to verify applicant eligibility and determine reimbursement amounts for DRP applicants as well as document the program accomplishments of CBDPP grant recipients. **Comments are due 04/03/2020.**

<https://www.federalregister.gov/documents/2020/02/03/2020-01907/agency-information-collection-activities-proposed-collection-public-comment-request-information>

**HRSA Establishes Tribal Advisory Council; Seeking Delegates**

The Health Resources and Services Administration (HRSA) is requesting comments on the establishment of its Tribal Advisory Council and is seeking nominations of 12 qualified Tribal officials, from the 12 Indian Health Service (IHS) areas, for consideration for appointment as voluntary delegate members of the HRSA Tribal Advisory Council (TAC). There should be one designated alternate for each TAC member. HRSA TAC members will have the opportunity to engage in meaningful consultation with agency officials, and to share a broad range of views determining the impact of HRSA programs on the American Indian/Alaska Native (AI/AN) health systems and the population. HRSA also seeks Tribes guidance in crafting innovative approaches to deliver health care and assisting with effective consultations. **Nominations are due 05/07/2020.**

<https://www.federalregister.gov/documents/2020/02/06/2020-02356/notice-of-establishment-and-solicitation-of-nominations-for-tribal-advisory-council>

Health IT/Broadband

**Closing The Health Disparity Gap For American Indians And Alaska Natives Through Health IT Modernization**

(01/27/20) In 2018, the HHS Office of the Chief Technology Officer, concerned about the impact of the VA’s decision to change health IT systems, launched the HHS/IHS HIT Modernization Project to evaluate the potential need for modernizing the RPMS. Over a span of 12 months, the agency partnered with the Regenstrief Institute to assess the RPMS and the opinions of people who rely on this system to deliver care to the tribal population. Using human-centered design methods and principles, initial discoveries through surveys and site visits (engaging with more than 2,000 users) were unsurprising, given the limited funding and support to the RPMS over the past years:

**Initial findings:**

- 60.3 percent of users believe the RPMS needs either significant improvements or a complete overhaul to meet the health care team needs;

- 30.3 percent rated the overall quality of the RPMS as poor or very poor;

- 16.1 percent are very dissatisfied with its ability to help them do their jobs better; and

- Approximately 14.0 percent of users interviewed during site visits feel they do not receive the training or support required to properly understand and operate the system.

<https://www.healthaffairs.org/do/10.1377/hblog20200122.299286/full/>

# Draft Federal Health IT Strategic Plan Supports Patient Access to Their Own Health Information

The U.S. Department of Health and Human Services (HHS) released the [draft 2020-2025 Federal Health IT Strategic Plan](https://www.healthit.gov/topic/2020-2025-federal-health-it-strategic-plan) for public comment. The draft plan outlines federal health information technology (health IT) goals and objectives to ensure that individuals have access to their electronic health information to help enable them to manage their health and shop for care. The strategic plan was developed by the HHS Office for the National Coordinator for Health Information Technology (ONC) in collaboration with more than 25 federal organizations. The draft also identifies current healthcare challenges and opportunities related to HIT. Explains how the federal government intends to use HIT to promote health; enhance care delivery; build a secure, data-driven system; and develop an interoperable HIT infrastructure. Includes discussion of rural needs and opportunities related to HIT. **Comments due 03/18/2020.**

<https://www.hhs.gov/about/news/2020/01/15/draft-federal-health-it-strategic-plan-supports-patient-access-health-information.html>

<https://www.federalregister.gov/documents/2020/01/30/2020-01733/information-collection-being-reviewed-by-the-federal-communications-commission>

**FCC: Information Collection Being Reviewed by the Federal Communications Commission**   
The Federal Communications Commission (FCC) is seeking public comment on an information collection for the Universal Service — Rural Health Care Program (RHC Program). Information will be used to evaluate the extent to which the RHC Program is meeting statutory objectives. **Comments are due by March 30, 2020.**

Office of Management and Budget

**Trump Administration Seeks to Revise Federal Grants Guidance to Reflect New Priorities**

On January 22, the Office of Management and Budget [proposed changes](https://www.federalregister.gov/documents/2020/01/22/2019-28524/guidance-for-grants-and-agreements) to the guidance for grants, cooperative agreements, and other types of federal financial assistance to support the President’s [Management Agenda](https://www.whitehouse.gov/wp-content/uploads/2018/03/The-President%E2%80%99s-Management-Agenda.pdf). All recipients of federal grant awards, including Tribes and Tribal organizations, could be impacted. For agreements with Indian Tribes, the provisions of the Indian Self-Determination and Education and Assistance Act (ISDEAA) will govern.

The proposed changes are an update to the Uniform Guidance located in Title 2 of the Code of Federal Regulations (2 CFR 200). The proposal reflects some of the priorities of the 2019 [Grant Reporting Efficiency and Agreements Transparency Act](https://www.congress.gov/bill/116th-congress/house-bill/150), which President Trump signed into law on December 30 and requires agencies to use government wide data standards in their information collection from grant recipients. The Act allows the White House Office of Management and Budget Director to permit exceptions on data reporting standards for federal awards granted to Indian Tribes and Tribal organizations consistent with the Indian Self-Determination and Education Assistance Act, only after the Director publishes a list of exceptions and submits the list to the Senate Committee on Homeland Security and Governmental Affairs and the House Committee on Oversight and Reform. Comments on the Guidance are due March 23, 2020.

https://www.federalregister.gov/documents/2020/01/22/2019-28524/guidance-for-grants-and-agreements

**More HHS/CMS Information Collection Requests/Proposed Rules/Notices**

**CMS released new guidance on 2020 QHP enrollee experience survey reporting requirements guidelines**

**(01/10/20)** The ACA requires CMS to develop a quality rating for each marketplace product based on quality and price and a survey to assess enrollee satisfaction with marketplace plans. This data is intended to assist consumers in comparing plans but an also be used for oversight, and by insurers for quality improvement. The guidance is largely technical and identifies the changes that CMS made to the survey’s sample frame and completeness thresholds as well as the agency’s rationale for making these changes. The 2020 survey includes two new variables—enrollee education and enrollee employment—that insurers should fill using available administrative data. ([Health Affairs](https://www.healthaffairs.org/do/10.1377/hblog20200115.821815/full/))

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-on-2020-QHP-Enrollee-Survey-Sample-Frame-Reporting-Requirements.pdf>

**CMS: Agency Information Collection Activities: Submission for OMB Review; Comment Request**   
CMS is requesting comments on three proposed collections of information. The first is the extension of a currently approved collection: Electronic Funds Transfer Authorization Agreement; the second is a new collection of Medicare Enrollment Application for Clinics/Group Practices and Other Suppliers Revision; and the third is a revision to the currently approved collection: Contract Year 2021 Plan Benefit Package (PBP) Software and Formulary Submission. **Comments due 02/13/2020.**

<https://www.federalregister.gov/documents/2020/01/14/2020-00426/agency-information-collection-activities-submission-for-omb-review-comment-request>

**The Office of Disease at HHS: Diabetes Federal Programs Meeting**

The Office of Disease Prevention and Health Promotion at HHS has announced a **virtual meeting on February 19th, 2020** to discuss improvements to the coordination and leveraging of federal programs related to diabetes and its complications.

<https://www.federalregister.gov/documents/2020/01/31/2020-01871/meeting-of-the-national-clinical-care-commission>

**CMS information request: Cooperative Agreement to Support Navigators in Federally-Facilitated Exchanges**

Use: Section 1311(i) of the PPACA requires Exchanges to establish a Navigator grant program under which it awards grants to eligible individuals and entities (as described in Section 1311(i)(2) of the PPACA and 45 CFR 155.210(a) and (c)) applying to serve consumers in States with a FFE. Navigators assist consumers by providing education about and facilitating selection of qualified health plans (QHPs) within the Exchanges, as well as other required duties. Entities and individuals cannot serve as federally certified Navigators and carry out the required duties without receiving federal cooperative agreement funding. **Comments due 02/24/2020.**

<https://www.federalregister.gov/documents/2020/01/24/2020-01210/agency-information-collection-activities-submission-for-omb-review-comment-request>

**CMS Information Request: Early and Periodic Screening**

CMS has issued a notice on a comment requests for their annual early and periodic screening, diagnostic and treatment participation report, to assess its effectiveness. **Comments due 02/27/2020.**

<https://www.federalregister.gov/documents/2020/01/28/2020-01348/agency-information-collection-activities-submission-for-omb-review-comment-request>

**HHS Collection Request: Pregnancy Prevention Program**

HHS issued a notice on filling the evidence gap about the efficacy and effectiveness of existing pregnancy prevention programs among high-risk, vulnerable, or understudied youth. **Comments are due 02/28/2020.**

<https://www.federalregister.gov/documents/2020/01/29/2020-01573/agency-information-collection-request-30-day-public-comment-request>

**GAO: Request for Nominations for the Physician-Focused Payment Model Technical Advisory Committee (PTAC)**   
The Government Accountability Office is requesting nominations for the Physician-Focused Payment Model Technical Advisory Committee, which will provide feedback on physician payment models to the Department of Health and Human Services (HHS) Secretary. **Nominations are due 02/28/2020.**

<https://www.federalregister.gov/documents/2020/01/30/2020-01699/request-for-nominations-for-the-physician-focused-payment-model-technical-advisory-committee-ptac>

**CMS Deadline for Draft Manual for State Payment of Medicaid Premiums**

Deadline to Submit Comments on the Draft Manual for State Payment of Medicare Premiums is **02/29/2020**

https://www.cms.gov/index.php/medicare-medicaid-coordination/medicare-medicaid-coordination-office/state-payment-medicare-premiums

**End Stage Renal Disease Application and Survey and Certification Report**

CMS issued a notice for public comment on the End Stage Renal Disease Application and Survey and Certification Report. **Comments due on 03/09/2020**. <https://www.federalregister.gov/documents/2020/02/07/2020-02357/agency-information-collection-activities-submission-for-omb-review-comment-request>

* Evaluation reports and publications on CMS’s [Comprehensive End-Stage Renal Disease Care (CEC) Model,](https://innovation.cms.gov/Files/reports/cec-annrpt-py2.pdf) [Accountable Care Organization Investment Model](https://innovation.cms.gov/Files/reports/aim-second-annrpt.pdf), and the [Next Generation Accountable Care Organization Model](https://innovation.cms.gov/Files/reports/nextgenaco-secondevalrpt.pdf).

**CMS Agency Information Collection Activities: Medicare Current Beneficiary Survey**  
CMS is requesting public comment on a revision to the Medicare Current Beneficiary Survey. *Use:* CMS is the largest single payer of health care in the United States. The agency plays a direct or indirect role in administering health insurance coverage for more than 120 million people across the Medicare, Medicaid, CHIP, and Exchange populations. A critical aim for CMS is to be an effective steward, major force, and trustworthy partner in supporting innovative approaches to improving quality, accessibility, and affordability in healthcare. CMS also aims to put patients first in the delivery of their health care needs. **Comments due 03/16/2020.**

<https://www.federalregister.gov/documents/2020/01/14/2020-00424/agency-information-collection-activities-proposed-collection-comment-request>

**CMS Information Collection Request: Pharmacy Benefit Manager Transparency**

The Centers for Medicare and Medicaid Services (CMS) has issued a notice for public comment on the prescription benefit information that the pharmacy benefit managers (PBMs) must provide to HHS. **Comments due** **03/30/2020**.

<https://www.federalregister.gov/documents/2020/01/28/2020-01463/agency-information-collection-activities-proposed-collection-comment-request?utm_campaign=subscription+mailing+list&utm_source=federalregister.gov&utm_medium=email>

**Update to Required Prior Authorization List: DMEs and Phases**

(02/10/2020) Pre-publication notice from the Centers for Medicare and Medicaid Services announcing updates additions to the list of Healthcare Common Procedure Coding System (HCPCS) codes on the Required Prior Authorization List of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). These changes are effective January 1, 2020 and will be implemented in two phases. **Effective 5/11/2020.**

<https://www.federalregister.gov/documents/2020/02/11/2020-02644/medicare-program-update-to-the-required-prior-authorization-list-of-durable-medical-equipment>

##### **Notice: Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2020 Through September 30, 2021**

This notice announces the calculated Federal Medical Assistance Percentages (FMAP) rates, in accordance with sections 1101(a)(8) and 1905(b) of the Social Security Act (the Act), that the U.S. Department of Health and Human Services (HHS) will use in determining the amount of Federal matching for state medical assistance (Medicaid). **Effective 10/01/20.**

<https://www.federalregister.gov/documents/2019/12/03/2019-26207/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for>

**Final Rules**

**Basic Health Program; Federal Funding Methodology for Program Years 2019 and 2020**

This document provides the methodology and data sources necessary to determine federal payment amounts for program years 2019 and 2020 to states that elect to establish a Basic Health Program under the Affordable Care Act to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable. **Effective 01/06/2020.**

<https://www.federalregister.gov/documents/2019/11/05/2019-24064/basic-health-program-federal-funding-methodology-for-program-years-2019-and-2020>

**Annual Civil Monetary Penalties Inflation Adjustment**

HHS released a final rule updating the regulations on the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 as well as Federal Food, Drug and Cosmetic Act. **Effective 01/17/2020.**

<https://www.federalregister.gov/documents/2020/01/17/2020-00738/annual-civil-monetary-penalties-inflation-adjustment>

**CMS, HHS: Patient Protection and Affordable Care Act; Exchange Program Integrity**

This final rule revises standards relating to oversight of Exchanges established by states and periodic data matching frequency. This final rule also includes new requirements for certain issuers related to the collection of a separate payment for the portion of a plan's premium attributable to coverage for certain abortion services. **Effective 02/25/2020.**

<https://www.federalregister.gov/documents/2019/12/27/2019-27713/patient-protection-and-affordable-care-act-exchange-program-integrity>

<https://www.federalregister.gov/documents/2020/02/18/2020-03069/medicare-program-medicare-secondary-payer-and-certain-civil-money-penalties>

**Medicaid & Medicare News**

**Trump budget calls for cutting Medicaid, ACA by about $1 trillion**

(02/10/20) The budget proposal released on Monday includes a familiar list of deep cuts to student loan assistance, affordable housing efforts, food stamps and Medicaid, reflecting Mr. Trump’s election-year effort to continue shrinking the federal safety net.”

<https://thehill.com/policy/healthcare/482378-trump-budget-calls-for-cutting-medicaid-aca-by-about-1-trillion>

**RE: Medicaid Fiscal Accountability Rule**

(02/05/20) [A regulation proposed by the Trump administration, an arcane fiscal accountability rule, that involved the tightening of federal oversight and approval over complex financing strategies that states have long used to help pay for their share of the $600 billion program. This could lead to big cuts for Medicaid.](file://C:\Users\MMartinez\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\H5SYUPSW\A%20regulation%20proposed%20by%20the%20Trump%20administration,%20an%20arcane%20fiscal%20accountability%20rule,%20that%20involved%20the%20tightening%20of%20federal%20oversight%20and%20approval%20over%20complex%20financing%20strategies%20that%20states%20have%20long%20used%20to%20help%20pay%20for%20their%20share%20of%20the%20$600%20billion%20program.%20This%20could%20lead%20to%20big%20cuts%20for%20Medicaid) <https://www.usnews.com/news/business/articles/2020-02-05/trump-rule-could-lead-to-big-medicaid-cuts-governors-warn>

**Medicaid Block Grant Policy Could Face High Legal Hurdles**

(01/28/20) The plan under consideration to let states receive lump sum for Medicaid. One of the big obstacles is lack of authority to waive statute around federal match

A policy being weighed by Trump administration officials that would let the federal government give states a set amount to spend on Medicaid would face tough legal challenges. Attorneys say a guidance for states on how to apply for block grants would struggle to survive challenges, especially if they focus on provisions in the Medicaid law that determine how the government finances the federal-state program for the poor. “It’s very hard to square the Medicaid statute with a true block grant proposal,” Nicholas Bagley, a health law professor at the University of Michigan and former Justice Department attorney, said.

Block grants have become the latest flash point in an ideological battle being waged over Medicaid spending. Conservatives are pushing to reverse sizable increases in enrollment and spending in what they see as a “welfare” program. In contrast, their opponents view the increases, which flow from provisions in the Affordable Care Act allowing states to expand their Medicaid programs, as a success story that has allowed millions more Americans to have much-needed health coverage.

<https://news.bloomberglaw.com/health-law-and-business/medicaid-block-grant-policy-could-face-high-legal-hurdles>

**Other News**

Administration

**White House Office of National Drug Control Policy Releases Rural Community Action Guide**

(01/31/20) Today, the Trump Administration released a [new tool](https://www.usda.gov/sites/default/files/documents/rural-community-action-guide.pdf) to assist rural community leaders in building an effective local response to the crisis of addiction. The [Rural Community Action Guide](https://www.usda.gov/sites/default/files/documents/rural-community-action-guide.pdf) includes background information, recommended action steps, and promising practices for a range of issues related to drug addiction in rural America.

<https://www.whitehouse.gov/briefings-statements/new-tool-empowers-local-leaders-take-action-rural-drug-addiction/>

**Trump Administration Executive Order on Combating Human Trafficking and Online Child Exploitation in the United States**

(01/31/20) the U.S. Department of Justice announced that the White House Task Force on Missing and Murdered American Indians and Alaska Natives will coordinate with combating human trafficking and online exploitation.

<https://www.whitehouse.gov/presidential-actions/executive-order-combating-human-trafficking-online-child-exploitation-united-states/>

### **HHS issues additional extension for grandmothered plans**

(01/31/20) HHS has issued another extension for [grandmothered (transitional) health plans](https://www.healthinsurance.org/obamacare-enrollment-guide/should-i-keep-my-grandmothered-health-plan/). Under the latest guidance, these plans can renew as late as October 1, 2021, and can remain in force until the end of 2021. As was the case in prior years, HHS is letting states decide whether to allow grandmothered plans to be renewed; the majority have done so in prior years. But even in states that allow these plans to renew, the decision is ultimately up to the insurers, as they can choose instead to terminate their grandmothered plans and transition enrollees to [ACA-compliant plans](https://www.healthinsurance.org/glossary/aca-compliant-coverage/). Over the next several weeks, HealthInsurance.org will track states’ responses to the latest announcement.There are 32 states where grandmothered individual market plans are still in existence as of 2020.

<https://www.healthinsurance.org/obamacare-enrollment-guide/should-i-keep-my-grandmothered-health-plan/#yes>

**BIA: Indian Entities Recognized by and Eligible To Receive Services From the United States Bureau of Indian Affairs**

(01/30/20) **Publishes the current list of 574 federally recognized tribal entities. Each tribal entity is eligible for funding and services from the Bureau of Indian Affairs by virtue of their status as an Indian Tribe.**

<https://www.federalregister.gov/documents/2020/01/30/2020-01707/indian-entities-recognized-by-and-eligible-to-receive-services-from-the-united-states-bureau-of>

**Trump Administration Launches Presidential Task Force on Missing and Murdered American Indians and Alaska Natives**   
(01/29/20) The U.S. Department of Justice announced the White House task force on missing and murdered American Indians and Alaska Native held its first meeting. Describes how the task force will work with tribal governments, develop protocols, and increase awareness to address the high rates of violence towards Native community members.

<https://www.justice.gov/opa/pr/trump-administration-launches-presidential-task-force-missing-and-murdered-american-indians>

#### **HHS Lifts Limit On Fees For Patients Requesting Health Data Be Sent To Third Party**

(01/29/20) Cohen, Subscription Publication) reports HHS “lifted a limit on fees that providers and companies are allowed to charge when a patient requests to send their health data to a third party after a federal judge nixed the policy.” US District Judge Amit Metha “ruled that some portions of a 2016 HHS guidance are impermissible under the Administrative Procedure Act, which governs how federal agencies develop regulations and conduct notice-and-comment rulemaking.”

<https://www.modernhealthcare.com/law-regulation/federal-court-voids-2016-hipaa-guidance-third-party-fees>

**Congressional Hearing on Trump Administrations Proposed Changes to Federal Poverty Calculation**

(02/06/20) The hearings were part of a two-day series, “A Threat to America’s Children,” to assess the impact of the administration’s actions on child poverty, housing, hunger and health. House Republicans argued, however, that the hearing on changing the calculation was “premature” because the Trump administration has only solicited public comments about possibly revamping how the government measures poverty.

The guidelines can be found here: <https://aspe.hhs.gov/poverty-guidelines>

<https://www.aha.org/news/headline/2020-02-05-subcommittee-holds-hearing-poverty-measure-calculation>

Rural Health

**New Index Ranks America's 100 Most Disadvantaged Communities**   
(01/30/20) Summarizes findings in a new index of Deep Disadvantage, which reveals that rural counties are much more likely to be disadvantaged. Researchers discuss how poverty has an effect on life expectancy and highlight the importance of addressing these disparities among rural populations.

<https://poverty.umich.edu/news-events/news/new-index-ranks-americas-100-most-disadvantaged-communities/>

**Transportation Issues Hinder Opioid Treatment in Rural Areas, Experts Tell House Committee**   
(01/30/20) Coverage of a recent U.S. House of Representatives hearing held to determine if federal funding is being used effectively to address the opioid crisis and to discuss how states are overcoming lack of transportation as a barrier to treatment services in rural areas. West Virginia was one state to speak on their success, stating that for the first time in ten years, opioid overdose deaths decreased due to increased naloxone distribution, additional training, and the utilization of Quick Response Teams.

<https://www.dailyyonder.com/transportation-issues-hinder-opioid-treatment-in-rural-areas-experts-tell-house-committee/2020/01/30/>

**HHS Report on Substance Use Disorder and Child Welfare in Rural Areas**

(01/20) A report on challenges in providing SUD Treatment to Child Welfare Clients in Rural Communities.

**Key findings:**

• Rural communities often lack the resources to provide services to parents struggling with substance use issues. Rural economics, transportation and technological limitations exacerbate these challenges.

• Child welfare agencies and substance use disorder treatment providers face particular challenges to collaboration with one another in rural communities. Stigma, lack of anonymity and misinformation compound these issues.

• Strategies specifically tailored to rural communities are needed to improve service access, develop workforce capacity and improve collaboration. <https://aspe.hhs.gov/system/files/pdf/263216/ChallengesIssueBrief.pdf>

# Regulation Review and Impact Analysis Report (RRIAR)

* [RRIAR v.9.09](https://www.nihb.org/tribalhealthreform/wp-content/uploads/2019/10/NIHB-RRIAR-v.9.09-w-Index-2019-10-07.pdf) as of September 2019
* [RRIAR v.9.10](file:///\\NIHB-SBE\Folder%20Redirection\MMartinez\Desktop\%09https:\www.nihb.org\tribalhealthreform\wp-content\uploads\2019\11\NIHB-RRIAR-v.9.10-w-Index-2019-11-08a.pdf) as of October 2019

# NIHB & TTAG Recently Submitted Comments (2020)

* TTAG Letter re: Medicaid Fiscal Accountability Regulation—Submitted 02/01/20
* NIHB Comment on Nebraska Section 1115 Waiver—Submitted 01/17/20

**MMPC Letters:** <https://www.nihb.org/tribalhealthreform/mmpc-regulation-comments/>

**TTAG Letters:** <https://www.nihb.org/tribalhealthreform/>

# Information and Resources

1. **CMS: Tribal Affairs Guidance & Resources | Medicaid.gov**

Various resources and guidance for states regarding Tribal affairs. <https://www.medicaid.gov/medicaid/indian-health-and-medicaid/tribal-affairs-resources/index.html>

1. **Federal Register**

“Health Care Reform” <https://www.federalregister.gov/health-care-reform>

1. **HRSA – Visit the** [**FORHP Policy page**](https://urldefense.proofpoint.com/v2/url?u=https-3A__lnks.gd_l_eyJhbGciOiJIUzI1NiJ9.eyJidWxsZXRpbl9saW5rX2lkIjoxMDUsInVyaSI6ImJwMjpjbGljayIsImJ1bGxldGluX2lkIjoiMjAxOTEwMTcuMTE2MTg3NjEiLCJ1cmwiOiJodHRwczovL3d3dy5ocnNhLmdvdi9ydXJhbC1oZWFsdGgvcG9saWN5L2luZGV4Lmh0bWwifQ.d3p0JzfscwTpU8mNfpZxzD91v6j-5Fb9wKM6LN-2Dtm3Ink_br_70265244280-2Dl&d=DwMFAA&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=Wg6IkxT-wOb--DZFvASlj7ZgT4HJhAGc-veaPQ_szfU&m=L3DGLoca_39413v9wNm6drofzJc7Z2jQkSX5Z0tQJAs&s=0lamvtwo7hpGxkRcJqqektrc50i8W-ITWQYFCFv9w2c&e=) **to see all recent updates.**

**\* Sources for the Regs Roster include:** [**National Association of Medicaid Directors**](https://medicaiddirectors.org/)**,** [**Rural Health Information Hub**](https://www.ruralhealthinfo.org/news/federal-register)**, HHS/HRSA/CMS Alerts, and other email digests, as well as *Politico* and *Health Affairs*.**