

Centers for Medicare & Medicaid Services
COVID-19 All State Call
August 18, 2020
3:00 pm ET

Coordinator: Welcome and thank you for standing by. All participants will be in a listen only mode until the question and answer session throughout the call. During that time if you'd like to ask a question please press star one, clearly record your name when prompted. As a reminder, this call is being recorded. If you have any objections you may disconnect at this time. Now I would like to turn the call over to your host, Ms. (Jackie Glaze). You may begin. Thank you.

(Jackie Glaze): Thank you. And good afternoon, everyone and welcome to today's All State Call. I'll now turn to Karen Shields, our Deputy Center Director, and she will provide an overview of today's call, and introduce our guest speakers. Karen?

Karen Shields: Thank you, (Jackie). Welcome and thanks for joining us today. Today we wanted to discuss how COVID-19 is affecting the American Indian and Alaska Native populations, and how the Indian Health Service and tribes are responding.

Given the health disparities and the disproportionate impact of COVID-19 on this population, we wanted to make sure that we shared this important perspective. We have invited two guests that will provide an overview of how the Indian Health Service and tribal health programs have been meeting the challenges of COVID-19 in tribal communities.

We are very excited to have with us Rear Admiral Chris Buchanan, the Deputy Director of the Indian Health Service known as IHS. He will provide an overview of the impact of COVID-19 in Indian Country. Rear Admiral

Buchanan is a member of the Seminole Nation of Oklahoma. He is joined by Rear Admiral Michael Toedt, MD, who serves as the Chief Medical Officer at IHS.

In addition, we also welcome Ron Allen of the Jamestown S'Klallam Tribe of Washington State, who serves as the Chairman of the CMS Tribal Technical Advisory Group. Ron will give a rundown of some of the work tribal health programs have been doing to address the COVID-19 pandemic as well as the tribes' coordination with the states and other agencies during this public health emergency.

After the two tribal presentations, Sarah Delone, the Director of CMCS's Children and Adult Health Programs Group, will pose a few questions to our presenters, and facilitate a discussion. We will then open it up to your questions on the tribal presentation.

After that, we will hear from Danielle Daly in our CMCS State Demonstration Group, who will provide an update on a new 1115 evaluation technical assistance document that CMS is releasing today. This TA document is designed to support state planning and decision making during this public health emergency. We'll discuss each of these areas and associated considerations during the presentation.

Jackie Glaze: Karen, are you still there?

Karen Shields: Yes, I am. Sorry. Before we get started - Yes, my apologies. I must put myself on mute by mistake. So before we get started, I want to share a few updates regarding the Provider Relief Fund. First, HRSA has indicated that the application rate for Medicaid and CHIP providers, is continuing to move slowly upward. Recent data shows that over 10% of providers on the curated

list have applied in 17 states. And the highest state-specific application rate is now over 33%. Also, this past Friday, HHS announced a \$1.4 billion-dollar targeted distribution for almost 80 freestanding children's hospitals.

This distribution follows two prior distributions announced in June and July that targeted safety-net hospitals. Friday's announcement will ensure that certain freestanding children's hospitals not affiliated with the larger hospital systems, also receive the financial relief they urgently need to offset revenue losses and increased expenses as a result of COVID.

Qualifying freestanding children's hospitals must be either an exempt hospital under CMS's inpatient prospective payment system or a HRSA children's hospital graduate medical education facility. Eligible hospitals will receive 2.5% of their net revenue from patient care. Qualifying freestanding children's hospitals will begin receiving funds this week. As always, we appreciate your support and assistance in getting the word out to your providers and then making us aware of any issues that your providers are experiencing and trying to apply.

So let's jump to our agenda. I am pleased to turn the program over at this time, to Rear Admiral Chris Buchanan.

Rear Admiral Chris Buchanan: Thank you, Karen and good afternoon, everyone. Thank you for the opportunity to provide an update on the Indian Health Service COVID-19 response activities. I want to first begin with the high level of some HHS activities followed by a quick snapshot on how IHS is continuing to prevent, detect, and treat COVID-19.

There have been a lot of COVID-19 activities happening throughout the Indian Health System. And beginning with last week, Secretary Azar visited

Anchorage, Alaska to meet with the local Tribal Health and Human Services leaders. He met with the Cook Inlet Tribal Council to see how they are taking all the necessary precautions in order to continue childcare services for their community.

He also saw how they were delivering job training and placement services virtually. He toured the Alaska Native Medical Center to observe the COVID-19 testing capacity and how they have adapted the challenges and delivering services during the COVID-19 pandemic.

He also visited the Anchorage Native Primary Care Center and met with the South-Central Foundation leadership, who developed the Nuka system of patient-centered care. He met with a lot of our Alaska Native tribal health consortiums, acknowledging them and other native organizations on making progress using new technology to deliver healthcare and human services in some of our most rural and remote places in America.

This stop was part of a nationwide tour by Secretary Azar, to hear from the healthcare workers on the front lines responding to the pandemic. Here at IHS we always appreciate the significant support provided by Secretary Azar and Deputy Secretary Hargan, and other senior leaders at HHS, as well as our CMS colleagues on the phone today and others in our operating and staff divisions, for prioritizing health programs and services of American Indians and Alaska Natives. Earlier this week, President Trump announced an agreement of up to \$1.5 billion with Moderna to manufacture and deliver 100 million doses of its investigational COVID-19 vaccine.

The data suggests that Moderna vaccine is safe and that patients who receive two immunizations produce high levels of neutralizing antibody activity against the Coronavirus, above the average levels of those observed in serum

taken from people with COVID-19 infections. At IHS we continue to engage with the HHS leadership of Operation Warp Speed, as they work to ensure expedited vaccine delivery across the US upon FDA approval. Operation Warp Speed aims to deliver 300 million doses of a safe, effective vaccine for COVID-19.

HHS also announced that eligible providers can submit applications for funds through the Providers Relief Fund. Several ways to do that and we provide several examples of that. The deadline for applying for these funds is August 28th. For more information on the Provider Relief Fund program, please visit the [HHS.gov/ProviderRelief](https://www.hhs.gov/ProviderRelief).

Also, IHS continues to participate with HHS leadership in virtual and HHS regional tribal consultation sessions. Thanks to tribes for their feedback. Tribes have provided ways we can work to improve our tribal outreach and coordination activities.

We always encourage tribes to participate in upcoming regional consultation sessions that focus on regional-specific issues and also discuss programmatic and policy issues and concerns with HHS leadership on a national level. Today we are currently engaged with an HHS regional consultation involving Region 10, which includes Alaska and Portland IHS areas. IHS remains committed to engaging in meaningful tribal consultation with tribal leaders and conferring with urban Indian organizations. For more information about our regional tribal consultation sessions in upcoming activities, please visit the [HHS.gov](https://www.hhs.gov) and search consultation.

You may have heard that President Trump signed an executive order further expanding access to telehealth services during COVID-19 pandemic, especially in rural communities. Through this order the President is also

taking action to extend the availability of certain telehealth services after the current public health emergency ends.

The executive order also includes the HHS Secretary of Agriculture, Federal Communications Commission, and other agencies collaborating to develop and implement a strategy to improve rural health and access to healthcare by improving physical and communication infrastructure available to rural Americans.

These telehealth expansions build upon CMS's work during the public health emergency to more than double allowable telehealth services, greatly expanding access to high-quality care. As the country begins to reopen, we slowly bring our - and we're bringing our patients back into our facilities.

We want to make sure we are providing a safe environment for our most vulnerable patients. We have focused on efforts to maximize capacity to treat acutely ill patients, to conserve supplies, and minimize the risk of exposure. This is why we encourage the use of telehealth phone visits, telemedicine across the IHS.

Since the IHS-wide expansion of telehealth in April, IHS has experienced an almost 10 to 11-fold increase in telehealth visits per week. We look forward to continue to emphasize the importance and benefits of telehealth as we move forward.

Now I'll talk specifically about some of the activities IHS has done as we continue to move forward. Of course, we continue to work closely with our tribal and urban Indian organization partners, states, local and public health officials, and our fellow federal agencies. While the Indian Health Service system is large and complex, we realize that preventing, detecting, and

treating, and recovering from COVID-19 requires local expertise.

We continue to participate on regular conference calls with tribal and urban Indian organization leaders from across the country, to provide updates answering questions and hearing the concerns. We hold these calls on a bi-weekly frequency which involves the White House, the tribes asking questions. In addition, we engage in rapid tribal consultation and urban confer sessions in advance of distributing COVID-19 resources to ensure that funds meet the needs of Indian country. We're always grateful of Congress for supporting our efforts through the passage of several acts and legislation.

These laws have provided additional resources and authorities and flexibilities that have permitted IHS to administer nearly \$2 billion to IHS, tribal and urban Indian health programs to prepare for and respond to Coronavirus. These resources have helped us expand our testing, public health surveillance, healthcare services.

Moreover, they support the distribution of critical medical supplies, personal protective equipment in response to the pandemic. All of these resources are making a real difference in helping to fill our IHS mission as we continue to work with our tribal urban Indian organization partners to deliver crucial services during the pandemic.

The IHS continues to play a central role as part of an all of nation approach to prevent and detect and treat and recover from COVID-19 pandemic. We're partnering with federal agencies, state tribal, tribal organizations, and others, and universities to deliver on that mission. We're protecting our workforce through education, training and distribution of clinical guidance, and personal protective equipment.

We also protect our tribal communities through supporting tribal leaders and making their decisions about community mitigation strategies that are responsive to the local conditions and to protect the health and safety of tribal citizens, as those communities make plans to safely return to work.

We're detecting COVID-19 through screening in the state-of-the-art lab testing. Through the right health-led testing initiatives we've distributed a total of 470 Abbott ID Now rapid point of care analyzers, as well as hundreds of thousands of testing supplies for various testing platforms. The IHS National Supplies - yes?

Jackie Glaze: Chris, can I ask that you wrap up within the next minute, please?

Rear Admiral Chris Buchanan: I sure can. I'm about to wrap up here.

Jackie Glaze: Thank you. Thank you.

Rear Admiral Chris Buchanan: No problem. As of August 17th we've performed 571,727 tests in our American Indian/ Alaska Native communities which equates to 34.4% of our user population. And of those tests, 37,428 have been positive with a large geographic variation as much as 16.7% in our hard-hit Phoenix areas, to less than 0.8% in Alaska. I want to thank you guys for the opportunity to speak with you today. And of course, please stay safe and continue taking responsible actions to stop the spread of COVID-19. My pleasure to introduce Chairman Allen.

Chairman Allen, as mentioned earlier, is the Chairman of the Jamestown S'Klallam in Washington State. Ron was appointed to the Tribal Council in 1975. He served as the Chair since 1977. He's served four years as the President of the National Congress of American Indians, and a total of 26

years as an officer, since 1989.

Currently, President of the Washington Indian Gaming Association. Chairman Allen serves as Tribal Representative on advisory councils for the US Department of Interior, Health and Human Services, Department of Justice, and the Department of Treasury Internal Revenue Service. It's my pleasure to hand the floor over to Chairman Allen. Thank you.

Ron Allen: Well, thank you, Rear Admiral Buchanan. And I don't mean to be so overly formal here. I usually talk - refer to Chris as Chris, quite frankly. I agree - we have a very close relationship as well as Director (Weaki). Our - the tribe - the 574 tribes in America worked very closely with IHS, with regard to healthcare. And I appreciate the opportunity to talk to the All-State Medicaid directors. I had the opportunity to speak with many of you previously and by engaging and collaborating, coordinating, talking about best practices that we engage with.

The challenge that we have today in this COVID-19 pandemic, which has been exceptionally challenging for all of us, and using some of Chris's examples like in Alaska, we're very diverse. So you can compare the Alaskan villages throughout Alaska or to Navajo or to the Lakota tribes in the Great Plains or to our Eastern Seaboard tribes.

We have some great diversities and we have challenges I think many are well aware of, that's unique to our American Indian and Alaskan Native communities. You know, our ongoing challenges such as diabetes and heart disease, etc., that that make things really challenging.

Now with regard to all of our various clinics and those who have hospitals, now with this pandemic we've got some new challenges and that's particularly

how we coordinate with IHS and CDC and HRSA, SAMHSA and all the other agencies within HHS, that are trying to address the challenge that we have; the day to day challenges, much less the virus problem that we're all experiencing. So consultation is a big deal to us. Chris referred to us at the organizations. But I know that he knows that we're governments and we have this very unique relationship with the United States government.

And over the last 15 to 20 years and evolving in improved government to government relationship with the state and the State Department such as a Medicaid operation in each state. So in my state, Washington, we have been working very well. We have 29 tribes in my State of Washington and that will vary from state to state. There's I think about 35 states that actually have tribal governments in their state.

And so it will vary throughout the nation. In my state, we have 29. We have an organization called the American Indian Health Commission that all 29 tribes participate in. And we work closely with the state healthcare authority that administers that Medicaid program and tries to improve the coordination with regard to the challenges that they each and every one of us have.

So we totally agree with many of the comments, all the comments that Chris made with regard to, you know, how do we cope with the current situation while we're waiting for the vaccine to emerge, and so that we get better control over the virus in all of our communities. So we're all looking for the PPE equipment, the testing equipment whether it is Abbott machines or whatever equipment that is available to our different operations; getting them; getting access to them has been quite challenging for us.

And what we do in Washington in terms of coordinating with all of our clinics throughout the state east side to west side, we have regular joint trainings and

strategy sessions to talk about how we can improve our collaboration and coordination between the state operations, the private sector versus the tribal programs.

Mine as an example, I live in a very rural area west of Seattle. And one road in, one road out. But my clinic serves not just my tribal community but the community at large. So we serve in the north of 17,000 patients in our community. So a lot of people depend on us in terms of that testing. We've had to set up our coordination with the public officials on case investigations and tracing and setup, you know, emergency drive through testing, you know, because of people being so concerned. And then coordinating with the local community hospital, etc., on isolation quarantine facilities and capacities.

So it is in these last three-plus months has been - or four, however long it's been, we've been scrambling. And this is true all over Indian country. If it's true in my neck of the woods I know it's true elsewhere, whether you're looking at Minnesota, South Dakota, or California. So it is a huge deal for us in terms of how we coordinate.

So one of the points that we try to emphasize is that we have always been struggling because of the capacity and resources we have. So it's a heavy lift for us. And the improved coordination between state Medicaid and Medicare for that matter, coordination is really important to provide quality healthcare for Indians and Alaska Natives and then our non-Indian community that surrounds us as well. I will stop there.

Carolyn Hornbuckle is on the line from the National Indian Health Board that all of our tribes coordinate through. And I don't know if I'm missing some key points that we need to make. So let me pause quickly and see if Carolyn has some point that I'm missing.

Carolyn Hornbuckle: Thank you, Chairman Allen. Thank you very much, for allowing National Indian Health Board to take part in the call as well. We really appreciate the opportunity to just share some thoughts and share some information.

I know that some folks are very familiar with the Indian Health System overall, but I think that a couple of points that I would just kind of underscore is that we really are operating a health system that only gets appropriations covering a small percent of our needed care. So some estimates are up, you know, up as high as 50% of needed care is covered. But National Indian Health Board and our tribal partners estimate that it's quite a bit lower than that.

So it's really important, especially during this COVID time, to ensure that third party dollars are also flowing into our system. And the most important source of this third-party funding across Indian country is Medicaid. So this is a really important conversation and we are very glad to be engaged and we look forward to continuing that engagement.

We have a lot of things to share that we're doing in Indian Country that could really benefit the health system overall. And we have a lot of ways that we think that we can improve our operations and our engagement with all of you. So I'll just keep my comments to that. And I'm very glad to be on the call. Thank you, Chairman Allen for the opportunity to add in a couple of points.

Ron Allen: Okay. I think that's it for us.

Sarah Delone: Wonderful. Well, thanks. This is Sarah Delone with the Children and Adult health Program Group. Thank you, all three of you, for your extremely informative presentations. We are going to open up the lines shortly. So I

encourage folks participating in the call, to sort of think about and get ready to queue up their own questions.

But I did want to ask just a couple of questions to follow up on some of the things that you all talked about during your presentations, while others are thinking about their own questions. A couple of things - one is - and I think we know that telehealth has been extremely helpful.

I think Chris, you talked about some expanded capacity in the IHS facilities. State Medicaid and CHIP programs have been expanding their telehealth capacity during this emergency. And I'm wondering if you could talk a bit more about how telehealth has been helpful to delivery of health services in both IHS facilities and in your tribal communities. I'd love to hear from both of you. So flip a virtual coin and maybe Ron, maybe we can start with you?

Ron Allen:

Yes. Well without a doubt this experience has really opened up new opportunities. Without a doubt, the telehealth has become a big issue because people are so nervous about the virus and even going into a clinic makes them nervous. And when we're trying to provide distancing conditions in our lobbies as people are waiting to see the doctors, the telehealth has really become a new vehicle - new, I guess I can call it a vehicle, venue to help improve our services. So it varies from state to state in terms of the tribes being able to use telehealth and getting reimbursements for it.

We're discovering it's as costly for us in terms of the staffing, including the doctors that serve our clients. And so getting the full reimbursement is a big deal. It works in our state. It's not as successful in other areas. And that requires a lot of collaboration and support by the states and the tribes in their respective regions. But it's also challenging for us with regard to the capacity, the training of our clients - our patients, to be comfortable. One, do they have

computers; two, do they - are they comfortable using them? And three, are they confident that they're going to get the same kind of medical attention by the telehealth?

And we think that it's - it is the wave of the future to vastly improve the amount of services that we can provide. We have particular cultural issues that sometimes they don't want to leave the home. And so that has been a bit of an issue for us. And so this is a - this telehealth has been a vehicle for us to reach a lot of our elders, particularly and we have techniques in terms of using family and the youth around the family, to get that comfort level. So it works. And we think that it - we're gearing it up. We're discovering that the structure of our clinic at - it requires a different kind of pod setup, if I can say it that way, to make this thing work.

So it is going to make some - it's going to cause us to make some adjustments. But we also - it's not just Medicaid, it's Medicare. And then getting reimbursements for Medicare is a little more challenging to get a reimbursement rate. So that's a problem for us nationwide, with all of our clinics and hospitals.

Sarah Delone: All right. And Chris, do you have anything to add, and I wonder if you've had success in addressing any of the challenges that Ron has identified?

Rear Admiral Chris Buchanan: Sure. I just want to expand a little bit more. As mentioned earlier, in April IHS expanded the use of an agency-wide videoconferencing platform, that allows telehealth and almost any device in any setting, including at our patient homes.

Since April's telehealth expansion, I experienced greater than a 10 to 11-fold increase in telehealth visits from roughly 75 telehealth visits per week on

average, to now over 907 videoconferencing telehealth visits per week on average. That number doesn't include telehealth modalities, such as care provided on the telephones, which is common in bandwidth constraints in some of our rural and remote locations, as I mentioned earlier.

I just will expand a little bit that, you know, ten years ago as a CEO working in the clinic and at hospitals, the landscape's changed as Ron's mentioned earlier, you know, in just a few short months. But this is nothing new. Tribes continue to evolve and adapt and find solutions to the challenges that we have. So we're always learning from each other and appreciate insights as Chairman Ron Allen had indicated. Thanks.

Ron Allen: And this is Ron. So quick passages of the 1135 waivers can really help that process in order to get these reimbursements to start making this an option.

Sarah Delone: You're talking about only the Medicare side, Ron?

Ron Allen: Yes. Medicaid, I think. Yes.

Sarah Delone: We could probably keep talking about the telehealth, but let me move on to ask a couple of other questions until we can open up the lines. I think it was a Carolyn, you had mentioned, you know, real challenges with, you know, financial resources. And we know that there's been a decrease in third-party revenues at IHS and tribal facilities. Can, you know, either any or all of you talk about, you know, what is or has been done to lessen the impact resulting from that? Chairman Allen, I - oh go ahead, Carolyn.

Carolyn Hornbuckle: Oh, I'm sorry. Just a quick comment. I think that we just were kind of addressing telehealth and I do think that that is one of the ways that our tribal clinics and hospitals and IHS as well, are using telehealth to make sure that

patients get the needed care despite COVID-19 and despite their concerns of perhaps presenting at a clinic and being exposed. So telehealth certainly helps in that regard. But also it is really becoming a virtual lifeline for our clinics that are experiencing decreases in third party revenue. So telehealth allows us to keep our facilities open.

As I mentioned before we are, in some ways, a much more fragile health care system because of the lack of funding. So, you know, ensuring that those appointments can continue, it's not only good for patient care but it also is allowing this very vital and important system to continue. And that was one of the things that I was kind of trying to underscore that telehealth is actually one of those tools.

And then we also have seen across Indian country some really kind of innovative partnerships that have sprung up where tribes may have reached out to their Medicaid offices, their state Medicaid offices, and, you know, shared concerns about lack of broadband access or lack of equipment like cell phones or computers.

And, you know, in some cases those Medicaid offices maybe did not have the resources to bring to bear, but they were able to connect the tribe or tribe with other resources within the state government to, you know, to fill in gaps. So we're seeing really innovative work across the board. And that's the kind of work that we really want to highlight. We want to kind of spark that creative problem-solving. When we come together, we can really solve these problems

Adm. (Chris Buchannan): Yes, this is (Chris). I'd like to bring in Admiral (Michael Tote). (Michael Tote) is their Chief Medical Officer for Indian Health Service and allow him to share some of his experiences as it relates.

Adm. (Michael Tote): Thank you. Adm. (Buchanan). Certainly, I agree that one of the biggest challenges is having the infrastructure to deliver telehealth. So, you know, many of our systems may be set up to do that but our communities may not be. And so that's on the receiving end for smaller clinics as either providers or patients in their homes. And that's a big challenge.

And then as Chairman (Allen) mentioned, variability and reimbursement. One of the things that that's been done to lessen the impact, I believe, certainly is the CARES Act Provided Relief Fund. But you know in terms of it being a brave new world and telehealth being something that's here to stay, I think we look to the payment system reform for telehealth to lead the way in the future. As Chairman (Allen) said the costs don't go down in terms of providing visits. In fact, they probably go up in the short term because of the transition.

The new training that that needs to take place and then the delivery of the healthcare on those on the platforms that we deliver them on and then sharing of the medical record. The IHS is not a closed system like the V.A. so our patients are shared patients. Not only are we Medicaid providers, but in each of your states are patients also get referred out to other Medicaid providers that are not IHS Tribal Urban Indian Organization providers. So we really have to just emphasize strong communication with the state programs and you know early and frequent communication to help to make sure that we don't have health disparities in our in the population that we both serve. Thank you.

Ron Allen: Yes, this is (Ron), Adm. (Tote) has underscored some of our points here. And I'm glad he referred to the payer relief resources. That's been helpful. But it just it really is. It's working, but we're scrambling to make it work. So I just want to underscore the point that infrastructure and the resources to make it work can be in a challenging site. So even though telehealth is helping us and in solving problems that we have in certain areas, some of our areas and like

in my state I've got to two large tribes.

Very large land bases and one called the (Covhill Nation) and which was called (Yakama Nation). And anybody from Arizona certainly knows - understands the Navajo Nation or the Dakotas, Pine Ridge and some of those larger reservations. And Montana, same thing. There are very large communities and the infrastructure is not quite there. The strength of the infrastructure or the capacity is not there.

So even though you might be set up for it, they say the platform, you can't use it. So it's not that it's not the end-all, but it is part of the solution. And we certainly see it as going forward once we come out of the pandemic, we see it as a vehicle that really does need to be embraced by CMS and the tribes and IHS going into the future as well as the state. Because we're solving lots of complicated problems in very remote areas.

And I do I want to make sure I don't forget that when we talk about Indian Country we talk about the tribes, but we have a lot of urban providers who are struggling for many of the same reasons. And they're serving our American Indian, Alaska Natives as citizens in these very urban settings because the tribes, for the most part, are in rural America.

Jackie Glaze: Thank you (Ron). I'd like to also thank (Chris) for your presentations and I would like to be able to open it up for the audience so that they can ask questions of you. So I will ask the operator now if he will open the line so that we can take questions.

Coordinator: Absolutely. Thank you. At this time, if you would like to ask the question please press Star 1 and record your name unprompted. One moment to see if we have any questions.

Sarah Delone: So I wonder, (Jackie), if we're waiting for - as we're waiting for people if there's - if it makes sense for - if I have time for one more. We're running over and we need to move on.

Jackie Glaze: Yes. Yes. One more. That would be great thanks.

Sarah Delone: So I think one thing and, you know, (Ron) and Carolyn in particular I think alluded to some of the, you know, cooperation and collaboration that you've been able to achieve with some of the state Medicaid agencies. And I think one thing our audience may be particularly interested in is if there are any particularly successful examples or creative ways that you wanted to share or lessons learned. The things that didn't go so well with our audience in terms of addressing and tackling the problems. He spoke about it in particular around telehealth. So but if there's other areas also that you want to share that would be really helpful, I think for folks to hear.

Coordinator: Excuse me. We do have a question in queue.

Sarah Delone:: Oh okay, let's pause for that.

Coordinator: Our question comes from (Teresa Bellinger). Your line is open.

(Teresa Bellinger): Thank you. Good afternoon, everyone. My name is (Teresa Ballenger). I am a Native American liaison with New Mexico Medicaid. Chairman (Allen) alluded to drive-thru testing for COVID. We're doing a lot of drive-thru testing out here in New Mexico and Arizona both on the reservation and off the reservation.

What we're needing is guidance on how to build for the drive-thru testing. Is

that something we can bill for? Can we bill at the OMB rate? Is it the fee schedule rate? And then whoever administers that test does it have to - Can it be a public health nurse or does it have to be a nurse practitioner? Could you provide us some guidance on that? Thank you.

(Ron Allen): Well from - this is (Ron). As I understand it for us, it's worked for Washington State. That we got a waiver approved to allow us to bill the same rate for each of our patients as they go through the drive-thru testing. So if the four walls problem. And so it's work for us. Now other states are maybe having some little more challenges on that matter. And I don't know. I don't have all the facts there. (Carolyn) might know better than me.

But I do want to add another point to it. If the pandemic and the virus hangs in there and goes deeper into the fall and winter, these structures that we set up are temporary. And down your way and over in Arizona is hot. You've got to have ways to keep them comfortable to, the staff comfortable as they're going through and they're driving on through.

And so we're already scrambling about how we can prepare for it if it goes deep into the winter. Whether it's the second phase or whatever, but as far as recovery of the rate, it's worked for us because we've got a waiver approved. And that's the challenge. It does cost. You have to have staff out there prepared to go through the process. And the right kind of equipment so that they can know they can give - that they get the results timely.

(Teresa Bellinger): Thank you Chairman (Allen).

Carolyn Humbuckle: If it's okay, I would just also add that the National Indian Health Board, we actually have a COVID Resource Web page and it's got a lot of information and it kind of spans all areas that are covered related including

waivers that states have put forward to help address COVID. And we have all of the states that have tribes within their borders.

We have - we are updating it pretty continuously because these waivers are coming out very quickly. But we have little fact sheets on all of the states and what they've put forward and also some links to where you can find additional information if what we've shared is not getting into the details that you need. So I would just encourage you to go to NIHB's website and perhaps I can share that information and it can get disseminated after the call.

(Teresa Bellinger): Thank you, Ms. (Humbuckle).

Jackie Glaze: Thank you. Let me ask the operator if we have any other questions in the queue.

Coordinator: I'm showing no further questions.

Jackie Glaze: Okay, so (Sarah) do you want to ask your last question? And then we'll move on to our next agenda item.

Sarah Delone: Sure, just any of you if there's an example or two that where you feel like you had a particularly successful partnership and you know in solving a problem in a creative way, that you would like to share with our listeners.

Ron Allen: Well I had mentioned - This is (Ron). I mentioned earlier. It varies from state to state, but most of us have an inter-tribal organization that serves the tribes in each respective state. And ours does and they meet on a monthly basis. And now that because of the virus, we - they've agreed to mutual trainings, forums so that our clinic directors and the chief medical officers can engage with them with regard to best practices and ways to resolve the triangulating of

those that are found and how we handle those that are in quarantine and so forth.

So that collaboration works. It's time consuming. But that we've used these virtual meetings successfully whether it's Zoom or Microsoft, et cetera. It's worked very effectively and because we have a mutual interest. And I'll just leave it at that. That if it's not in existence, it's in the interest of the state to encourage the tribes to collaborate with them. Collaborate with each other with regard to these challenging matters.

Sarah Delone: And that's where you have just regular standing regular meeting times that you have set up, (Ron).

(Ron Allen): Yes, and it is stepped up now. I mean it could the virus - the pandemic is dominating the conversation. But there are other typical stuff that that is critically important to us as well.

(Chris Buchannan): Agree this is (Chris). I'll just echo Chairman Allen's comments. You know communication early and often is key. Some of the things that we've seen whether it's with the tribe, state or government. You know we've seen high positivity rates in our Region 9 which consists of Phoenix, Navajo, Tucson and California areas.

I could give several examples, but again as Chairman (Allen) said you know the partnership not only displayed between IHS, the tribes, the states, the governor's office, FEMA, the White House all working together to address the challenges that are presented. And each tribe is unique. So each approach would be - need to be unique also. So I just want to emphasize those topics.

Sarah Delone: Thank you and (Jackie) that's probably a good note to end on. And just to

thank you again both (Chris Buchannan) and (Ron Allen) for spending your time with us today. Very much appreciate it.

Man: Our pleasure.

Jackie Glaze: I will echo, (Sarah). Thank you both so much. So now we'll move on to (Danielle Daily), and she'll provide an update on the 1115 evaluation demonstration. (Danielle)?

(Danielle Daily): Great. Thank you, (Jackie). So hi, everyone. I'm very excited to be speaking with you all today. We have released a technical assistance document on Medicaid.gov that we wanted to share with you all. And this technical assistance document really represents a lot of work and a lot of thinking we've been doing about particularly about Section 1115 demonstration evaluations. And some of the challenges that you all might be experiencing now as you're trying to execute on those evaluation designs in light of the current public health emergency.

So, you know, we recognize that every state and their evaluators are facing different challenges. And every state and their evaluators are also in different phases of their evaluation activities as well. So there's not necessarily a one size fits all approach to overcoming some of these challenges. But what the technical assistance document does is it lays out some considerations for you as you continue to explore these areas with your evaluators.

And it also provides some key discussion questions for you to use as you're working through this with your evaluators as well. So it's really meant to be a tool to help and support you in making sure that everybody understands you know the important decisions that are at hand and kind of what some of those implications are.

So the technical assistance document focuses on five key evaluation areas; things like documenting demonstration implementation and evaluation changes, issues or challenges you might have now in collecting primary data collection, challenges using time trends and comparison groups, or isolating demonstration effects, as well as considerations for interpreting findings in light of the current public health emergency.

So as I mentioned each of the five areas we have a little bit of information for you all to consider as well as some key discussion questions that you can use in your conversations with your evaluators. I think in the interest of time I'll hit on perhaps just a few of them that might be of interest to you all. And then I would really encourage you all to take a look at the document that's up on Medicaid.gov. Following this call, we will send around the link to you also that you can have easy access to it as well.

So I think you know some of the things I would point out to you that would be important considerations to be discussing are, you know, particularly in the area of implementation changes. So given COVID 19 you know some of you have decided to pause some of your demonstration implementations in different ways. And so you know I think this definitely creates a unique challenge as evaluation designs were previously set up to evaluate those features.

You know, another interesting change is beneficiary and provider behavior is also changing. We just heard a lot of discussion about telehealth appointments and those kinds of things. And so there's likely to be some impacts of those behavior changes that we might end up seeing in demonstration evaluations as well. But those are important things that you can consider and discuss with your evaluators.

Similarly, you know, primary data collection such as interviews or surveys are likely to be very challenging. Right now some of you all may need to avoid in-person data collection. It's also possible depending on what's happened with demonstration implementation that you might need to update some survey instruments to reflect the changes in those demonstration policies. And so there's a lot to consider for those primary data collection activities. And so we have some important questions that you can use with your evaluators in that area as well.

And then I think you know the last points that I'll leave you all with is really that we recognize how challenging it can be to think about how you can really disentangle the effects of your Section 1115 demonstration from the effects of the pandemic. So we have a handful of questions that you can consider as well as you try to work through some of those considerations with your evaluator. You know and I think what we really hope for is that you all can kind of find a common ground.

And in doing so making sure that the interpretation of those findings accurately reflects some of the challenges that you are encountering with those analyses and that potential inability to disentangle some of those demonstration effects from the COVID effects. And so really just being upfront and transparent about that in your evaluation reporting will definitely go a long way.

So let me pause there because I do want to make sure that we do have some time for questions. And as I mentioned, we will be sending around an email and after this meeting and that email will contain the link for you so that you can have easy access to it. And of course we are always available for follow-up conversations as well. So (Jackie) I will, I'll turn it back over to you.

(Jackie Galze): Thank you, (Danielle). And we'll now open up the phone lines. If you have any questions for (Danielle), if you have any questions for our other speakers or any other questions you may have. So operator please open up the phone lines, please.

Coordinator: Yes ma'am. We have a question from (Melissa Gower). Your line is open.

(Melissa Gower): Hi good afternoon. This is (Melissa Gower) with the Chickasaw Nation. And I kind of going back to the first speaker and (Teresa)'s question about billing. And (Ron)'s answer, Chairman Allen's answer. For Medicaid, that is correct. We don't have any problems billing for Medicaid because they've done a waiver and have allowed us to do that.

But under Medicare, we have major problems. Medicare has not followed Medicaid's pathway in that. So we have a hospital-based system with the hospital and three outpatient clinics. And we have set up four tent sites. And for testing, we're getting paid like \$9 under Medicare which is a far cry from anyone else getting paid.

And so I have inquired to the Division of Tribal Affairs at CMS about this issue, a couple of times. And Mrs. (Marks) who's over that division is great. And she's working that up through the system to try to get some guidance and clarification and try to get that fixed for us, but it's killing our- it's really hurting us in being able to provide those testing services through COVID pandemic. Thank you very much. I appreciate it.

(Kitty Marks): And this is (Kitty Marks). Thank you (Melissa) for that question. I will follow up. We'll continue to follow up on that issue. Thanks.

Jackie Glaze: Operator do we have other questions?

Coordinator: I am showing no further questions.

Jackie Glaze: Thank you. (Karen), can I turn it over to you?

(Karen Shields): Absolutely. Thank you so much, (Jackie). And thank you so much to all of our guest speakers. Rear Admiral (Chris Buchanan) and (Ron Allen), (Danielle Dially), and guests for their presentations today. On our next all-state call, we'll hold it on Tuesday, August 25th. We will send out information about the topic. That will be forthcoming.

We look forward to having you all back there with us. If you have any questions, of course, that come up between these calls, please reach out to us, to your state leads. We're here to assist you. We want to thank you for your participation this week and every week and all that you do for the nation. Have a great afternoon.

Coordinator: All participants, this concludes today's conference. You may disconnect at this time. Thank you. Speakers, stand by.

End