Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

December 21, 2020

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244–1850

Re: Request for Information (RFI) on Redundant, Overlapping, or Inconsistent Regulations

Dear Administrator Verma:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), I submit this comment in response to the Request for Information (RFI) on Redundant, Overlapping, or Inconsistent Regulations notice published on November 27, 2020 in the Federal Register. We would like to take this opportunity to discuss regulations that we feel are not only redundant and inconsistent but are also harmful to the Indian health care system. Specifically, we want to address the inconsistencies in the grandfathered Tribal FQHC regulations, the fact that, despite being a sovereign government, Tribes cannot pay Medicare Part B Premiums for beneficiaries, and the fact that Tribes are exempt from the broader cash price publishing regulations but are not exempt from the ones that are directly related to COVID-19. We hope that the agency is able to address these concerns.

Trust Responsibility

The United States owes a special duty of care to Tribal Nations, which animates and shapes every aspect of the federal government's trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government's unique responsibilities to Tribal Nations has been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.[1] In 1977, the Senate report of the American Indian Policy Review Commission stated that, "[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people." This trust responsibility is highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

> Importantly, the Federal Government has a unique legal and political government to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments.[2]

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[1] The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. *See* Seminole Nation v. United States, 316 U.S. 286 (1942), United States v. Mitchell, 463 U.S. 206, 225 (1983), and United States v. Navajo Nation, 537 U.S. 488 (2003).

[2] Introduction, "Cross-Agency Collaborations", https://www.hhs.gov/about/strategic-plan/introduction/index.html

The trust responsibility establishes a clear relationship between the Tribes and the federal government.[3] The existence of this truly unique obligation supplies the legal justification and foundation for distinct health policy and regulatory making when dealing with American Indians and Alaska Natives (AI/ANs) and the Indian health system that provides their care. The federal government is responsible for ensuring the health of the Indian health system and its ability to provide health care to AI/ANs.

Make the IHS Outpatient Encounter Rate Available to All Indian Outpatient Programs that Request It (Permanent fix to Grandfathered Tribal Provider/FQHC Issue)

For nearly 20 years, the TTAG has been urging Medicare to authorize all Indian outpatient programs that request it to bill at the IHS outpatient encounter rate. Currently, otherwise similar clinics are paid at dramatically different rates depending upon whether they qualify as a "provider-based facility," a "grandfathered Tribal FQHC," a non-grandfathered Tribal FQHC, or none of the above—categories that largely depend on whether and when the facility was last operated by the IHS. Effective January 1, 2018, CMS eliminated the April 7, 2000 date restriction in the grandfathered provider-based Tribal facility rule at 42 C.F.R. § 413.65(m), which addressed the problem for a subset of Tribal healthcare facilities. Commenting on that proposed rule in 2017, TTAG asked that the date restriction also be removed for grandfathered Tribal FQHCs in 42 C.F.R. § 405.2462 for consistency. While CMS declined at the time, explaining that such a change would be outside the scope of the proposed rulemaking, it said it would consider doing so in a future rulemaking.[4] CMS's Tribal provider-based rules need to be updated to allow all Indian outpatient programs that request it to be able to bill at the IHS Outpatient encounter rate. Specific regulatory changes were forwarded by the TTAG to CMS in June 2020 (attached).

Sponsorship of Medicare Part B Plans

The TTAG has requested that Tribes be able to sponsor and directly pay for Part B premiums for their members. Currently, Tribes are able to reimburse individuals for the cost of Part B premiums, but the individuals themselves first have to pay the premiums. Tribes wish to simply pay Medicare the cost of the premiums for all the individuals they are sponsoring in one lump sum payment under a formal third-party group payer arrangement with CMS. CMS policy provides that employers, unions, states and local governments can do this, and the TTAG believes Tribes should be able to do so as well.

Allowing Tribes to sponsor Medicare Part B plans would also be recognition of the fact that, like states, Tribes are sovereign entities. If states have the ability to sponsor Part B premiums, then we believe that Tribes should also be able to do so. We believe that the current mechanism of requiring Tribes to reimburse individuals is ineffective and results in many people not being able to access Medicare Part B. It is inconsistent that state and local governments can sponsor Medicare Part B premiums while Tribes, which are also sovereign governments, are unable to do so.

Price Transparency Regulations

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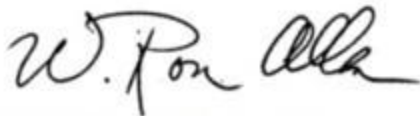
[3] In Worcester v. Georgia, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third party actors.
[4] 82 Fed. Reg. 38289 (August 4, 2017), https://www.govinfo.gov/content/pkg/FR-2017-08-14/pdf/2017-16434.pdf

The TTAG also believes that there is a latent inconsistency with the requirements to publish a cash price for services that are offered by the IHS and Tribal providers. In the broader price transparency rule that was finalized in November 2019, federally owned or operated facilities, including IHS and Tribal hospitals and facilities, were explicitly excluded from having to publish prices for their services. The agency recognized that this was appropriate because "these facilities do not provide services to the general public and the established payment rates for services are not subject to negotiation. Instead, each of these facility types is authorized to provide services only to patients who meet specific eligibility criteria.[5]" We agree with this reasoning and thank the agency for acknowledging the unique position of Indian health providers. However, we are concerned because the lack of a similar exemption in the final rule, CMS-9912-IFC, published on November 6, 2020, which mandated the publishing of cash prices for the COVID-19 tests. In the 2019 final rule, the agency recognized the unique attributes of the Indian health system, which makes publishing a cash price impractical. It is inconsistent with the agency's prior rulemaking to not grant an exemption to the requirement to publish the cash price for COVID-19 tests. Given that the requirement to publish a COVID-19 cash price carries penalties for not complying, this regulation is harmful because it exposes Indian health providers to a penalty for a regulation for which compliance is impractical. The TTAG will be submitting a comment on this final rule.

Conclusion

The TTAG wants to thank the agency for the opportunity to respond to this RFI. We believe that the outlined regulations are not only inconsistent but also harmful to our populations and the Indian health system. We hope that the agency can address these concerns in future rulemaking. Thank you in advance for your consideration of our comments.

Sincerely,



W. Ron Allen, Chair – Jamestown S'Klallam Tribe

Chair, CMS Tribal Technical Advisory Group

CC: Devin Delrow, Associate Director, HHS Office of Intergovernmental and External Affairs

Kitty Marx, Director, CMS Division of Tribal Affairs

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[5] 84 Fed. Reg. 65532 (November 27, 2019), https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf