Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
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December 23, 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: CMS-9912-IFC, "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency"

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 CMS-9912-IFC, which provided additional policy and regulatory revisions in response to the COVID-19 Public Health Emergency (PHE). The IFC contains a number of important provisions that will help providers respond to the PHE. The TTAG would like to thank CMS for ensuring that the costs of administering COVID-19 vaccines will be reimbursable by Medicare Part B, Medicaid, CHIP and private insurance. We also think it is important that the IFC ensures that the vaccine will be made available to all without any cost-sharing. While American Indians and Alaska Natives (AI/ANs) are exempt from cost-sharing in the Medicaid program, it is important that cost sharing be waived for anyone receiving the vaccine no matter what form of coverage they may have.

The TTAG does have several concerns with this proposed regulation. First, we are concerned about the requirement to publish a "cash price" for COVID-19 tests. The Indian health system does not charge AI/AN beneficiaries for services provided at our hospitals and facilities.[1] CMS recognized this unique status of the Indian health system when it exempted Indian health programs from the price transparency regulation that was promulgated last year by deeming publication of the IHS OMB rates to meet those requirements. We believe that the same exemption should apply here. The Department publishes OMB approved inpatient and outpatient rates for IHS and Tribally-operated facilities in the Federal Register each year, and that should be deemed to meet the statutory requirement to publish a cash price for Indian health care providers.

We want to ensure that AI/ANs are insulated from any benefit cuts that states may elect to make during the pandemic in response to the increased flexibilities offered in this regulation. Finally, we want to ensure that the need for states to consult with Tribes during the 1332 waiver process is

[1] Federal law prohibits the Indian Health Service from charging AI/ANs for their care. It allows tribally-operated programs to do the same, and to the best of our knowledge all tribal programs serve AI/AN beneficiaries at no charge. Indian Health Care Improvement Act, Section 813 (25 U.S.C. 1680c).

preserved, even when the waivers are rushed to respond to an emergency. Thank you in advance for your consideration of our comments.

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.[2] 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.[3]

The trust responsibility establishes a clear relationship between the Tribes and the federal government.[4] The Constitution's Indian Commerce clause, Treaty Clause and Supremacy clause, among others provide the legal authority and foundation for distinct health policy and regulatory decision making by the United States when carrying out its unique trust responsibility to provide for the health and welfare of AI/ANs and support for the Indian health system that provides their care.

Price Transparency Regulations

The TTAG is concerned about the requirement to post a cash price for COVID-19 tests and feels that this is inconsistent with prior regulations issued by the agency. 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 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. We appreciated that the agency recognized that publishing a cash price is impractical for the Indian health care system.

In its explanation of the current regulation, the agency says, "[a]t § 182.20, we are defining 'cash price' as the charge that applies to an individual who pays in cash (or cash equivalent) for a

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[2] 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).

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

[4] 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.

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

COVID–19 diagnostic test.[6]" and then states, "the 'cash price' would be the maximum charge that may apply to a self-pay individual paying out-of-pocket.[7]" IHS and Tribal facilities do not have self-paying patients, with very rare exceptions, and they are expressly allowed to serve both AI/ANs and non-AI/ANs at no charge in order to "prevent the spread of a communicable disease or otherwise deal with a public health hazard."[8]

The TTAG acknowledges that this regulation is being promulgated in response to section 3202(b)(1) of the CARES Act, which required cash transparency on COVID-19 tests. We also agree that requiring cash transparency is important because it assists uninsured patients who must pay for their own care to make decisions that maximize their savings and increase their access to health care. However, we do not believe that the provision is reasonably understood to require a health care system that does not charge its patients to post a price that it would charge to hypothetical patients. Further, we are concerned that advising IHS and Tribal facilities to list "$0" on their websites may result in lower or no reimbursements from private insurers and impede their ability to recoup our costs of providing tests.

We believe that the agency can and should use its enforcement discretion to exempt Indian health care providers, as it did in its other price transparency rules. 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. We believe that this must be addressed quickly.

Insulate AI/AN Medicaid Beneficiaries from Benefit Cuts

Section 6008 of FFCRA provides States with an additional 6.2 percent federal match during the public health emergency. One of the conditions for receipt of these funds is that States must not reduce eligibility or benefits. The IFC implements a new set of rules that gives States more flexibility to reduce benefits during the pandemic. It would allow States to move beneficiaries from one group to a different group with a more limited set of services, limited visits and increased copays. The rule creates three tiers of services: services that provide minimum essential coverage; services that do not provide minimum essential coverage but do cover COVID-19 testing and treatment, and services that do not provide minimum essential coverage and do not cover testing and treatment.

The rule allows States to move individuals to groups that have less coverage or increased cost-sharing, so long as they are in the same tier. The TTAG appreciates that the IFC would exempt AI/AN beneficiaries from any cost sharing regardless of this new flexibility. However, AI/ANs could still be moved into a group with fewer benefits covered. We do not believe that CMS has the authority to allow states to move beneficiaries from one group to another with more limited benefits, as doing so would be inconsistent with the maintenance of effort requirements of FFCRA.

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[6] 85 Fed. Reg. 71142, 71152 (November 6, 2020) https://www.govinfo.gov/content/pkg/FR-2020-11-06/pdf/2020-24332.pdf

[7] *Id.*

[8] Indian Health Care Improvement Act, section 813(d) [25 USC 1680c(d)]. Under limited conditions, the Indian health system may provide additional services to non- AI/ANs and charge them a reasonable amount for their care, if doing so will not result in a diminution of services to AI/ANs. Some Indian programs do so because they are the only health care provider in their community or region and the nearest non-Indian option is inaccessible as a practical matter. But the overwhelming majority of services are furnished at no charge to AI/AN patients. (25 USC 1680c).

In any event, services received through IHS and Tribal facilities are already reimbursed at 100 percent FMAP and should not be affected by this rule. As a result, we believe that states should not be able to move AI/ANs to groups with fewer benefits in the same tier.

Require States to Engage in Meaningful Tribal Consultation in Section 1332 Waivers

Section 1332 of the Affordable Care Act allows States to apply for a waiver of certain marketplace rules so long as the waiver provides equivalent coverage. The IFC provides states with additional flexibility to curtail notice and comment, including Tribal consultation, for Section 1332 waivers both before they are submitted to CMS and after they are approved. Under the current regulations at §§ 33.112 and 155.1312, states are required to provide a public notice and comment period prior to submitting new section 1332 waiver applications. This process includes the requirement to consult with Tribes:

> As set forth in §§ 33.112(a)(2) and 155.1312(a)(2), as part of the public notice and comment period, a state with one or more federally recognized tribes must conduct a separate process for meaningful consultation with such tribes, if applicable. As HHS and the Department of the Treasury explained in the 2012 Final Rule preamble, this tribal consultation must be conducted in accordance with Executive Order (E.O.) 13175, and, as E.O. 13175 also applies to Medicaid, a state may use a Medicaid consultation process to satisfy the consultation needed for a section 1332 waiver (77 FR 11700, 11706).[9]

The IFC states that the Secretaries of Treasury and Health and Human Services have determined that "the current section 1332 regulations regarding state and Federal public notice procedures and comment period requirements may impose barriers for states pursuing a proposed waiver request during the PHE for COVID–19." *Id*. To address these issues, the IFC allows the Secretaries to modify the State public notice and comment requirements for section 1332 waivers. These waivers could allow States to no longer require public in person meetings and to hold meetings virtually instead.

While we support changes that would allow States to implement Section 1332 waivers with the speed necessary to address the public health emergency created by COVID-19, we are concerned that States may overlook their Tribal consultation obligations. Tribal consultation is central to the government-to-government relationship between the United States, the States and Tribes. It is more than just mere public notice and the opportunity to comment. Rather it is the obligation of the United States to engage in informed and meaningful dialogue with Tribes on issues that may affect them.

The TTAG recognizes that Tribal consultation may need to be streamlined to avoid any delay in implementing policy changes to address the current pandemic, but Tribal consultation cannot be abandoned altogether. Yet that appears to be contemplated in the IFC. Regarding Tribal consultation under the new waivers, the IFC provides only that:

> HHS and the Department of the Treasury especially encourage states to strive to obtain meaningful input from potentially affected populations, including low-income residents, residents with high expected health care costs, persons less likely

[9] 85 Fed. Reg. 71142, 71178.

> to have access to care, and *members of federally recognized tribes*, if applicable, as part of any alternative public participation process.

Encouraging states to 'strive' to obtain meaningful input from members of federally recognized Tribes falls far short of meeting the United States' obligation to engage in a separate Tribal consultation process required by Executive Order 13175. That Order requires federal officials to engage in regular and meaningful consultation and collaboration with tribal officials in development of "regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes." Exec. Order No. 13175, 65 Fed. Reg. 67249 (Nov. 9, 2000).

While the TTAG recognizes the need to streamline the process in the face of the current pandemic, the Departments cannot abandon their duty to require States to engage in tribal consultation altogether. Simply encouraging states to "strive" to get input from a variety of affected populations, including Tribal citizens, does not meet the mark.

Conclusion

The TTAG has concerns about this regulation and its impact on the Indian health care system. We are concerned about the requirement to post a cash price for COVID tests, the potential for states to modify the Medicaid benefits for AI/AN beneficiaries, and the potential for states to avoid Tribal consultation when issuing Section 1332 waivers. We trust that the agency will addresses these concerns, which we feel negatively impact the Indian health care system, fail to take into account the unique nature of our system, harm our patients, and imperils Tribal consultation. Thank you in advance for your considerations of our comments.

Sincerely,

W. Ron Allen

W. Ron Allen, Chair – Jamestown S'Klallam Tribe
Chair, CMS Tribal Technical Advisory Group