



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

October 20, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via regulations.gov

Re: Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting

Dear Dr. Brooks-LaSure:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to provide a response to the Centers for Medicare and Medicaid Services (CMS) proposed rule, "Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting" (CMS-2440-P).

Preamble to Comments:

Before commenting specifically on this proposal, we highlight the important context in which TTAG's comments are offered, and which should inform CMS's consideration of them: the deep inequities in this nation's health care delivery system, and the Biden administration's commitment and urgent effort to eliminate them. Over the last year the entire federal government, including CMS, has been working to respond to the President's Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (EO 13985).

For the first time, the federal government is taking a systematic approach to address equity issues. CMS has responded by first issuing its CMS Strategic Plan, "Pillar: Health Equity" that laid out CMS' definition of health equity and a broad strategy to advance equity through its programs. More recently, CMS has published its Framework for Health Equity 2022-2032, which is a more detailed ten-year plan intended to address equity and health disparity issues across Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces.

An important fact about health disparities is that American Indian and Alaska Native (AI/AN) people were once one of the healthiest people on this continent, before colonialism and the United States policies of termination, assimilation, and boarding schools caused an "intergenerational pattern of cultural and familial disruption"¹ that drive health disparities to this day. These drivers have manifested in some of the worst

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health disparities for AI/AN people, including extraordinarily high and disproportionate rates of infant and maternal mortality, cancer, cardiovascular disease, depression and other behavioral health conditions, among other ailments. The recent Department of the Interior Boarding School Report explains that “Native Americans continue to rank near the bottom of all Americans in terms of health, education, and employment. Many AI/ANs face unique challenges and harsh living conditions resulting from the United States having removed their tribes to locations without access to adequate resources and basic infrastructure upon which their tribal governments can foster thriving communities.”²

It is imperative to acknowledge that efforts to address these disparities are often complicated by culturally inappropriate interventions and an inadequate understanding of the historical effects of United States policies and ongoing trauma of AI/AN people.³ It is this history that is the root cause of the significant health disparities that affect AI/AN populations.

The TTAG is deeply appreciative that the President’s EO 13985 and the CMS Framework for Health Equity provide an opportunity to focus on these concerns, and that the CMS Framework provides an opportunity to design, implement, and operationalize policies and programs to address health equity issues. The TTAG has always taken the position that CMS has ample legal authority to undertake distinct policies and programs specifically focused on AI/AN beneficiaries and the IHS programs that provide their care, because of their unique legal status under the U.S. Constitution and the duties owed by the federal government under its treaty and trust responsibilities to AI/ANs.⁴

Under established principles of Indian law, programs and policies that are specifically established for Indigenous people and organizations do not constitute prohibited race-based classifications; rather, they are based on the unique political relationship between the federal government and Indian Tribes. This unique legal relationship, taken together with EO 13985 and CMS’ Framework for Health Equity, provides a sound basis for CMS to adopt the TTAG recommendations on the Proposed Rule. We trust you will agree that the TTAG recommendations are directly related to CMS’ Framework discussed in “Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps.” These TTAG’s recommendations fit clearly in the intended outcomes of this chapter of the Framework as well as other priority areas of the Framework.

Comments:

The TTAG supports the Agency’s proposal to establish requirements for mandatory annual state reporting of the Core Set Measures for Medicaid and CHIP. We support the efforts by CMS to promote health equity and appreciate the variety of ways the Agency aims to do so. This proposal for the stratification of data among demographics, delivery type, and other measures will provide a new tool for identification of health disparities among patient populations.

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Timely access to this data is necessary to our efforts to advance health equity in Indian Country. It serves as a mechanism to hold states accountable for the quality of care provided to our people enrolled in Medicaid and CHIP programs by enhancing monitoring and oversight on states' individual programs and performance. We are hopeful that these reporting requirements will improve the data that is available to Indian Country, enhance CMS oversight of state Medicaid and CHIP programs, and enable more meaningful comparisons of state performance to help hold state Medicaid agencies accountable.

Regarding reporting on delivery system type, we recommend CMS stratify this measure further to reflect the managed care entity itself, rather than simply recording "managed care" vs. "fee-for-service." With the growing trend toward value-based care, this data point would be incredibly helpful in keeping these entities accountable for the care they provide their patient populations.

It is our understanding that, if finalized, these reporting requirements would increase the reporting burden on states and would *not* increase the burden on our IHS or Tribal facilities. However, if this is not the case, we urge that CMS provide the same opportunity for technical assistance to Tribes as it proposes to provide to states. If this is the case, we encourage that CMS take a creative and thoughtful approach to supplementing this reporting effort by Tribes.

As you know, IHS and Tribes submit claims to receive reimbursement for services at the all-inclusive rate. As an example, in Arizona, they are receiving reimbursement by the Arizona Health Care Cost Containment System (AHCCCS) if the patient is enrolled in a managed care plan. Claims data from these operations could be the source of information to supplement this reporting requirement. Of course, this data needs to be evaluated if it provides a meaningful comparison to the data collected from states for the purposes of this proposal but let this serve as an example of the opportunity for data collection to take any potential burden off of IHS and Tribal facilities. We strongly recommend that any additional reporting requirement would be met with the necessary funding to support that change.

Conclusion

We appreciate your consideration of the above comments and recommendations and look forward to engaging with the agency further.

Sincerely,



W. Ron Allen, CMS/TTAG Chair
Jamestown S'Klallam Tribe, Chairman/CEO