Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 50 F Street NW | Washington, DC 20001 | (202) 507-4070 | (202) 507-4071 fax

August 17, 2023

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 to: Chiquita.Brooks-Lasure@cms.hhs.gov

Re: Follow Up from the Centers for Medicare and Medicaid Services Tribal Technical Advisory Group Face-to-Face Meeting

Dear Administrator Brooks-LaSure:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I would like to express our deep gratitude and appreciation for your continued commitment to the top concerns of Indian Country. I have included some of the key issues raised during the July 2023 TTAG Face-to-Face Meeting and look forward to working with you and the rest of CMS to accomplish these health priorities for Indian Country.

I. Workgroups to Address TTAG Priorities

As you know, the TTAG developed its regulatory/administrative and legislative priorities to provide a roadmap for CMS to address health equity in the Indian health system. The TTAG regulatory/administrative priorities propose specific steps CMS can take – on its own authority – to expand the Medicaid services available to AI/ANs, empower Tribal programs to design and tailor Medicare and Medicaid services to their unique needs and cultures, as well as to provide more uniform and equitable Medicare and Medicaid reimbursement to Tribal programs. The TTAG formally adopted these priorities in March 2023.

During the meeting of the National Indian Health Board's (NIHB) Medicare, Medicaid, and Health Reform Policy Committee (MMPC) on July 25, 2023, committee members decided to establish workgroups on various TTAG legislative and administrative priorities to bring the necessary CMS folks together with MMPC/TTAG members to find solutions. Some of these priorities are administrative and can be accomplished without legislation. We want CMS subject matter experts to work through each of these administrative priorities with the workgroups we have established. **NIHB will contact you to coordinate these groups, and we hope CMS will engage and work with us to advance these goals.**

II. Reimbursement for Traditional Healing and Other Indian Specific Demonstration Waiver Requests

Traditional healing has well-documented, demonstrable health benefits and should be reimbursed like other service delivery types. In October of 2022, CMS approved Arizona's 1115 Demonstration Waiver extension request but did not approve Arizona's traditional healing demonstration. At the July TTAG meeting, we heard from Daniel Tsai that we should expect to see approval of this traditional healing request around the end of this year. We appreciate that CMS hopes Arizona's waiver will be an example and lead the way for the remaining states that have proposed reimbursement for traditional healing.

We understand that the requests vary on various aspects, from the types of services to the payment structure, but we hope this will be an example of how traditional healing can promote well-being in Indian Country in communities – and for individuals – whose practices of health may extend outside of options currently available within mainstream American medical practice. **In support of traditional healing, we request that Administration leadership attend the White House Traditional Healing Summit this year.** In particular, we would like to see support from Vice President Kamala Harris.

Beyond traditional healing, we urge CMS to consider other waivers that benefit Indian Country. We are very encouraged by the waivers CMS has approved that authorize Medicaid reimbursement for specific health-related social needs like utility costs and housing deposits, transition and moving costs, medically necessary home accessibility modifications, healthy meal preparation and home-delivered meals, and cooking supplies. We look forward to getting more of those waivers approved in states that have Indian Tribes. **We want to ensure that these waivers allow Indian health care providers to participate.**

Tribes are concerned that some may limit reimbursement to certain types of entities, like managed care providers or health service organizations, and want to make sure that Indian health care providers who provide these types of services to their citizens can participate in these demonstrations.- **We request to work with CMS to develop Indian-specific authorities that could be included in a state demonstration project to address these needs in Tribal communities and to work with state demonstrations group to develop templates to address health-related social needs in Tribal communities that could be included in state demonstration waivers.**

We want to thank CMS for approving several demonstration waivers over the years that include provisions specific to Indian health care providers. In October of 2022, CMS approved the Arizona Demonstration Waiver extension, and maintained Indian-specific provisions authorizing tribal health programs to be reimbursed differently from other health care providers. The waiver extension allowed tribal health care providers not to be subject to an annual limit for dental services that applied to other health providers. **We would like CMS to continue supporting and approving**

demonstration waivers that include provisions to address the needs of the Indian health system.

III. Medicaid Unwinding – Redeterminations and Data Sharing

Tribal leaders are very concerned with how many AI/ANs are losing their Medicaid coverage. Kaiser Family Foundation reports that over 70 percent of Medicaid enrollees are being disenrolled in some states. Most disenrolled people lose coverage not because they no longer qualify for Medicaid but for technical "procedural" reasons (e.g., because an individual did not respond to a letter or email). Kaiser Family Foundation studies show that over 71 percent of current Medicaid terminations result from "procedural" reasons. Over 80 percent of disenrollments in Oklahoma are for "procedural" reasons.

Additionally, NIHB's internal analysis estimates that between 99,000 and 338,00 AI/AN Medicaid beneficiaries may lose coverage during the unwinding, with many of these being attributable to procedural disenrollment. These procedural disenrollments are unacceptable. We appreciate CMS issuing guidance that encourages states to work with Tribes and Tribal health programs, but it is clear that just encouraging states is not working – only nine states currently sharing with CMS. **We request that CMS require states to work with Indian Health Service (IHS), Tribal, and Urban (I/T/U) facilities to share AI/AN enrollment data.** This request should include not only the names of AI/AN Medicaid enrollees slated for termination each month on a rolling basis but also enrollees' date of birth, Medicaid ID number, social security number, and last known address. In other words, all appropriate identifying information.

We request that CMS pause the redetermination process in states not adhering to this data-sharing requirement. There is currently no inventive or enforcement mechanism in place to ensure that states adhere to data sharing requirements. We appreciate leadership hearing our concerns during the TTAG meeting and that the transfer of individuals from Medicaid coverage to the Marketplace has been a conversation. We appreciate the Administration taking this matter seriously – ensuring that folks receive coverage through the Marketplace.

TTAG understands that Alaska Medicaid is "deprioritizing" rural Alaska residents during its redetermination process. We previously asked the state to push Alaska Natives to the end of the redeterminations, but the state said no. Further, we understand that CMS has told a handful or so of states to pause redeterminations when it finds it necessary and appropriate to do so when it finds an issue. We understand that CMS would like us to bring issues and information to CMS when we find this critical, and we look forward to working with you to address these concerns and pause redeterminations when necessary and will bring specific concerns to the CMS Division of Tribal Affairs (DTA), as discussed.

IV. Four Walls Interpretation

As we have discussed at many TTAG meetings, CMS should fix the four walls issue and authorize providers of clinic services to be reimbursed for services provided outside

the four walls of the clinic. **We are glad that CMS understands this issue's importance in Indian Country.** We appreciate the support and work that Dan Tsai has committed to finding a solution that works for us and CMS within the statutory limits it must work within. We understand it is a complicated issue that the agency is working through, and we appreciate the partnership thus far and the understanding that "from a policy standpoint, it's a no-brainer," as Mr. Tsai agreed with the group.

CMS has interpreted the Medicaid clinic benefit to exclude services furnished offsite by clinic staff, except to homeless individuals. IHS and Tribal programs that are enrolled in Medicaid as providers of clinic services have long provided and been reimbursed by the Medicaid program for services provided by their staff outside the physical four walls of the facility, including vital services they have furnished for decades at the offsite locations where they are most effective, such as schools, community centers, patients' homes, and by mobile crisis response teams. CMS clearly recognizes the adverse impacts of this cramped interpretation of the statute and has worked to mitigate them by granting and extending an enforcement grace period and allowing Tribal clinics to be redesignated as "FQHCs," which have no four-walls restriction. However, the four walls option has not been implemented by all states with tribal programs, and even in states that have taken it up, the option leaves out some services and is entirely unavailable to programs operated directly by the IHS.

While the TTAG appreciates these efforts by CMS, the approach is misguided, and CMS has the authority to interpret the clinic benefit more broadly to include offsite services furnished to all clinic patients. In our view, CMS's current interpretation of the benefit is based on a misreading of the Social Security Act and CMS's regulations, and it is profoundly contrary to public health, especially in the wake of the COVID-19 pandemic. **We request that CMS revisit and revise its interpretation.**

In approaching the solutions to these issues, we ask that CMS recognize that while the Tribal FQHC option is not viable for many states, it should remain an option for those programs that it does work for. **We realize the complexity of this issue, and we ask leadership to continue to engage the TTAG in deliberation and discussion of potential fixes to ensure that whatever decision is made does not harm our I/T/U facilities.**

V. Transition to Managed Care/ACOs by 2023

It's important to understand that managed care works differently in Indian Country, and even if an exemption is provided to our citizens, the effect this shift will have on the provision of Medicare and Medicare providers will also impact our Medicare beneficiaries. Because our payment structure is so different, it's not an easy fit for our programs and our people to interact with or become a part of an ACO. We ask that CMS consider the impact on the Indian health system when moving toward the goal of transitioning all Medicare beneficiaries to ACOs by 2030. Continue to have the dialogue with us to ensure we will not be negatively impacted by the shift, either directly or indirectly – including the Medicare providers we interact with within our system.

VI. Invitation to Indian Country

I'd like to remind CMS leadership that they are always invited out to Indian Country to see how our programs work and to see the work we're doing in I/T/U facilities to serve our people. We think it would be beneficial for you all to see the challenges we face in many of our clinics and hospitals, so you can better understand our needs and how you can help us. We're thankful that leaders like Jon Blum have been able to see Indian Country, and we want to thank him for coming up to Alaska earlier this year.

Lastly, on behalf of TTAG I would like to thank you again for your continued engagement with Indian Country and for your support of the TTAG's Tribal health priorities. We urge you to continue to work with Tribes and Tribal organizations to advance these priorities and to always consider the unique circumstances around the delivery of health care in our communities. TTAG looks forward to working collaboratively with the agency as we continue to advance the health and well-being of American Indian and Alaska Native people.

Sincerely,

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

Cc:

Daniel Tsai, Deputy Administrator and Director of Center for Medicaid and CHIP, CMS
Meena Seshamani, Deputy Administrator and Director of Center for Medicare, CMS
Kitty Marx, Director of CMCS Division of Tribal Affairs, CMS