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

July 3, 2023

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

Submitted via regulations.gov

Re: Medicaid Program; Ensuring Access to Medicaid Services

Dear Administrator 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; Ensuring Access to Medicaid Services" (CMS-2442-P). This is an important step toward increasing coverage and removing barriers to care. However, we hope CMS considers the unique circumstances under which the Indian health system operates and how some of the proposals may not work for Indian Country or have overlooked Indian Country. We ask that you consider the following comments and recommendations from the TTAG as you finalize this rulemaking.

Preamble to Comments

Before commenting specifically on this proposal, we highlight important context including 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.

Important to understand about health disparities is that American Indian and Alaska Native (AI/AN) people were once one of the healthiest people on this continent, before United States' colonial policies of termination, assimilation, and boarding schools

caused an "intergenerational pattern of cultural and familial disruption"[1] that drives health disparities to this day. These drivers have manifested in 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]

Efforts to address these disparities are often feature culturally inappropriate interventions and inadequate understandings 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. 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." The TTAG's recommendations fit clearly within the intended outcomes of this chapter and other priority areas of the Framework.

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[1] "Federal Indian Boarding School Initiative Investigative Report", Department of Interior, Assistant Secretary Bryan Newland, May 2022.
[2] *Ibid*.
[3] "Indigenous Health Equity," Abigail Echo-Hawk, Director, Urban Indian Health Institute, August 7, 2019.
[4] *See* "Legal Basis for Special CMS Provisions for American Indian and Alaska Native," Appendix A, CMS-TTAG Strategic Plan 2020-2025.

Comments and Recommendations:

I. The Mandated 80 Percent Payment to HCBS is Inconsistent with Tribal Self-Governance

At § 441.302(k)(3)(i), CMS proposes to require that at least 80 percent of all Medicaid payments, including but not limited to base payments and supplemental payments, with respect to homemaker services, home health aide services, and personal care services, be spent on compensation to direct care workers. While the motivations behind this proposal are well-intentioned, it is inconsistent with other federal law governing the use of Medicaid reimbursements by IHS and Tribally operated programs. As a result, IHS and Tribally operated programs must be exempted from this requirement.

The Indian Health Service (IHS) Tribal Self-Governance Program recognizes that Tribal leaders and members are in the best position to understand the health care needs and priorities of their communities. Tribal governments continue to develop innovative solutions to the health care delivery challenges of their communities. Tribes consider the needs and circumstances of their members when selecting from available health care options.[5]

Congress recognized the importance of Tribal decision-making in Tribal affairs and the importance of the nation-to-nation relationship between the United States and Tribes through the passage of the Indian Self-Determination and Education Assistance Act (ISDEAA). Today, self-governance compacting affords Tribes the most flexibility to tailor health care services to the needs of their communities. As of February 27, 2023, the IHS has entered into 112 Compacts and 139 Funding Agreements with Self-Governance Tribes and Tribal organizations across all 12 IHS Areas.[6]

For CMS to mandate how Tribes and Tribal programs must spend this money, once obligated to them, is inconsistent with the right of Tribes and Tribal programs to treat their Medicaid reimbursements as program income under the ISDEAA, Section 508(j) of the ISDEAA provides:

> All Medicare, Medicaid, or other program income earned by an Indian tribe shall be treated as supplemental funding to that negotiated in the funding agreement. The Indian tribe may retain all such income and expend such funds in the current year or in future years except to the extent that the

[5] Tribes may choose one or a combination of the following options: (1) continue to receive direct health care services offered by the IHS to American Indians and Alaska Natives; (2) use the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA), Titles I and V, to assume responsibility for health care formerly offered by the federal government. Tribes may contract with the IHS through self-determination contracts and annual funding agreements under Title I or self-governance compacts and funding agreements under Title V; or (3) fund the establishment of their own programs or supplementation of ISDEAA programs.

[6] Indian Health Service, *Self-Governance Tribes*, https://www.ihs.gov/selfgovernance/tribes/, accessed on: July 3, 2023.

> Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) provides otherwise for Medicare and Medicaid receipts.

25 U.S.C. § 5388(j). Any regulation that purported to require a Tribal health program to spend a certain percentage of its Medicaid reimbursements on direct care workers would be inconsistent with this requirement.

It would also violate the Indian Health Care Improvement Act. Section 401 of the Indian Health Care Improvement Act, 25 U.S.C. § 1641, provides specific requirements and limitations on how Indian health care programs may spend Medicaid reimbursements. Tribal health programs may use their direct collections for any of the following purposes:

- As necessary to achieve or maintain compliance with the requirements applicable to the Medicare, Medicaid and CHIP programs; or
- To provide additional health care services; or
- To make improvements in health facilities or health programs; or
- For any health-care related purpose (including coverage for a service that would otherwise be provided within a contract health service delivery area under the PRC program); or
- To otherwise achieve the objectives of Section 3 of the IHCIA.

25 U.S.C. § 1641(d)(2). Section 3 of the IHCIA provides a broad set of objectives for Indian health. 25 U.S.C. § 1602. The Indian Health Care Improvement Act therefore authorizes Tribal health care programs to use Medicaid reimbursements for a wide variety of health care related purposes. Any regulation that purported to limit those uses to payment for direct health care workers would be inconsistent with that broad authority and therefore unlawful. As a result, Indian health care providers must be exempted from this requirement if CMS implements it.

II. Ensure Access to Medicaid Services by Adequately Covering Beneficiary Travel and Lodging Expenses

The TTAG has long advocated for the AI/AN people that live in the most remote locations. When it comes to the barriers of care that are a result of rural and remote living, Alaska faces many unique challenges. The hub of care provided to folks in Alaska is Anchorage, which is often hundreds of miles and a plane ride (or two, or three) away from a village. Most villages served in the Alaska Tribal Health system have no road access, meaning the nearest community with a pharmacist, a physician, or a psychiatrist is, on average, an hour or more away by airplane. This assumes adequate weather and available flights, which is not a guarantee.

If folks get over that first hurdle of transportation, the second hurdle is to afford lodging in the city over the course of their care. Oftentimes, there is only a flight or two each day in and out of Anchorage to remote areas. This means that, even for a simple procedure, folks must stay the night in town. However, TTAG representatives from the Alaska Area have identified significant issues in beneficiaries affording these stays, let alone even finding lodging in the first place. Alaska tourism peaks in the summer

months, significantly hiking up the prices. Medicaid reimbursement rates cannot compete with these inflated prices. A significant chunk of urban-based lodging simply refuses to take Medicaid, because the state falls short and Medicaid pays nowhere near the summer rates, which can reach $800 in the peak of the summer season.

III. Ensure Fee-for-Service Beneficiaries Retain the Same Access to Care as Those in Managed Care

Tribes are having a hard time finding space for their fee-for-service (FFS) beneficiaries. There are limited FFS beds remaining in facilities because managed care plans come in and are able to pay more, disincentivizing providers from taking FFS patients. The discrepancy in payment rates between managed care and FFS is driving this problem. The lack of space for FFS beneficiaries is essentially pushing them into enrolling in managed care simply to gain access to the care they need.

Additionally, this drives AI/ANs to seek care outside of the IHS/Tribal (I/T) system, which has a cascading impact on the Indian health system. We need CMS to work to ensure FFS is not left behind and restricted in this move toward increased beneficiary enrollment in managed care.

IV. Require AI/AN Beneficiary Representation on Committees and Groups CMS Proposes to Create

The proposed rule seeks to establish various groups to help inform states and the Secretary about Medicaid policy decisions. Unfortunately, it does not appear that AI/AN beneficiaries are clearly represented among these groups under the group composition requirements of the proposed rule, as currently drafted. Representation matters, and CMS must ensure that Indian Country has a seat at every table it creates.

At proposed § 441.312(g), CMS proposes to require the Secretary to consult with specifically enumerated interested parties to update the Home and Community Based Services Quality Measure Set. The Secretary must consult with (1) State Medicaid Agencies and agencies that administer Medicaid covered home and community-based services; (2) Health care and home and community-based services professionals; (3) Health care and home and community-based services professionals, providers, and direct care workers who provide services to older adults, children and adults with disabilities, and individuals with complex medical and behavioral health care needs who live in urban and rural medically underserved communities or who are members of distinct population sub-groups at heightened risk for poor outcomes; (4) Providers of home and community-based services; (5) Direct care workers and national organizations representing direct care workers; (6) Consumers and national organizations representing older adults, children and adults with disabilities, and individuals with complex medical needs; (7) National organizations and individuals with expertise in home and community-based services quality measurement; (8) Voluntary consensus standards setting organizations and other organizations involved in the

advancement of evidence-based measures of health care; (9) Measure development experts; (10) Such other interested parties as the Secretary may determine appropriate.

We respectfully request that this list expressly mention Tribally operated programs and urban Indian health organizations.

At proposed § 447.203(b)(6), CMS proposes to require states to establish interested parties' advisory groups to advise and consult on FFS rates paid to direct care workers providing home and community-based services. The proposed rule articulates the minimum composition of the interested parties' advisory group as including direct care workers, beneficiaries, beneficiaries' authorized representatives, and other interested parties impacted by the services rates in question, as determined by the State.

We urge CMS to expressly include Tribally operated programs and urban Indian health organizations in this list of interested parties. State engagement and cooperation with TI health programs varies dramatically and we think it best that CMS makes it clear that representation of AI/AN beneficiaries in these groups is required. Moreover, FFS rates have profound impacts on the bottom line of Tribally operated programs, as noted above.

Finally, at proposed § 431.12, CMS proposes to require states to create Medicaid Advisory Committees and Beneficiary Advisory Groups, outlining minimum requirements for those groups' composition at (d) and (e), respectively. Without copying the list here, we note that Tribally-operated programs and urban Indian health organizations are left off both of these lists.

As we note above, state engagement and cooperation with the Indian health system varies. Accordingly, we respectfully request that CMS expressly include Tribally operated programs and urban Indian health organization as required members of both the state Medicaid Advisory Committees and the Beneficiary Advisory Groups.

Conclusion

This rulemaking is an important step toward ensuring Medicaid and CHIP managed care enrollees get the care they need. However, we hope CMS remembers and consider the unique circumstances under which the Indian health system operates – which we have outlined above – and how some of the proposals in this rule may not work for Indian Country. 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